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Managing Complaints about Doctors: Stakeholder Perspectives of the Role of the Medical Council in Ireland

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Health Services Research Centre
Royal College of Surgeons in Ireland

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Foreword

I welcome this study of complaints about doctors. It is the first study of its kind ever undertaken in Ireland and gives us important information from the doctors and patients who had been through the existing Fitness to Practise Procedures of the Medical Council.

This research comes as we enter a time of great change for the medical profession in Ireland, for the Medical Council and for health services generally. The Medical Council felt it was important that we would have robust research and comprehensive data like this available to us and to the other stakeholders as we reach this new crossroads.

The research is a snapshot in time and is important in its examination of direct experiences and the lessons that can be learned from them. These lessons are both about the Council's procedures and the hierarchical systemic needs for the Irish health service as regards complaints about treatment. The research will inform the Council's development of its procedures and hopefully the development of national legislation and user (patient and doctor) friendly systems at a national and local level for issues that do not need the full impact of the Council's Fitness to Practise procedures.

I congratulate the Health Services Research Centre for a job well done. I want to thank my colleagues on the Medical Council and the staff for supporting and facilitating such an in depth examination of Council's activities. In particular, I want to thank most sincerely the patients and doctors who were willing to recall a traumatic period in their lives in order to help the appropriate evolution of the system. The research is very much an account of their experiences and hopes for change.

The Council will be forwarding copies to all the relevant stakeholders, most especially the Department of Health and Children as it continues its work on the new Medical Practitioners Bill. This research gives important pointers about the systems that need to be in place for the future. The data contributes to an informed understanding and provides an important benchmark against which we can measure progress in the future.

Dr. John Hillery

President

Medical Council

Preface

This study was commissioned by the Irish Medical Council and was conducted by the Health Services Research Centre (HSRC) at the Department of Psychology, Division of Population Health Sciences, Royal College of Surgeons in Ireland (RCSI) between April 2005 and July 2006.

The authors of the study are Ms Siobhán McCarthy, Medical Sociologist and Research Officer at the HSRC; Professor Hannah McGee, Health Psychologist and Chair of the Department of Psychology, RCSI; and Professor Ciaran O'Boyle, Psychologist and Head of the International School of Healthcare Management, RCSI.

We thank the many individuals who gave generously of their time and expertise:

- Staff of the Irish Medical Council including the President, Dr John Hillery, the Registrar, Mr John Lamont and the Deputy Registrar, Mr David Hickey. We thank Mr. William Kennedy (Legal Advisor and Head of Professional Standards), Ms Jane Horan, and Ms Katie Carroll; Dr Anne Keane (Head of Education Section), Ms Karen Willis and Ms Ciara McMorrow.
- Professor Gerry Bury, former president of the Irish Medical Council, Professor Tom O'Dowd, former board member of the Irish Medical Council; Mr Finbar Fitzpatrick, CEO and Mr Donal Duffy, Deputy CEO, of Irish Hospital Consultants Association for advising on study questionnaires; Ms Angela Connolly, Complaints Manager, Beaumont Hospital for valuable advice on hospital complaints systems.
- Members of the HSRC staff including Ms Rebecca Garavan who advised on telephone interview methodologies, Ms Hannah Donovan who conducted telephone interviews with the general public and Ms Agnieszka Rajda who assisted in data management.
- Professor James Williams and Ms Amanda Quail, of the Economic and Social Research Institute's Survey Unit, for providing advice on sampling for the general public survey.
- Finally, we acknowledge the co-operation of 476 stakeholders who gave of their time to participate in this study. We thank hospital staff who compiled the complaints statistics and members of the general public who participated in telephone surveys. We thank and acknowledge those who complained to the Irish Medical Council. We are also very grateful to those doctors who were complained against, for sharing their experiences.

As the first research project to investigate stakeholder views of the Irish Medical Council, we hope that these findings will assist those charged with promoting effective regulation of the medical profession in Ireland. We thank the Irish Medical Council for the opportunity to carry out the project and we value the opportunity to contribute to an Irish evidence base for improving medical regulation.

Views expressed are those of the authors.

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1 Report Overview

1.1 Introduction

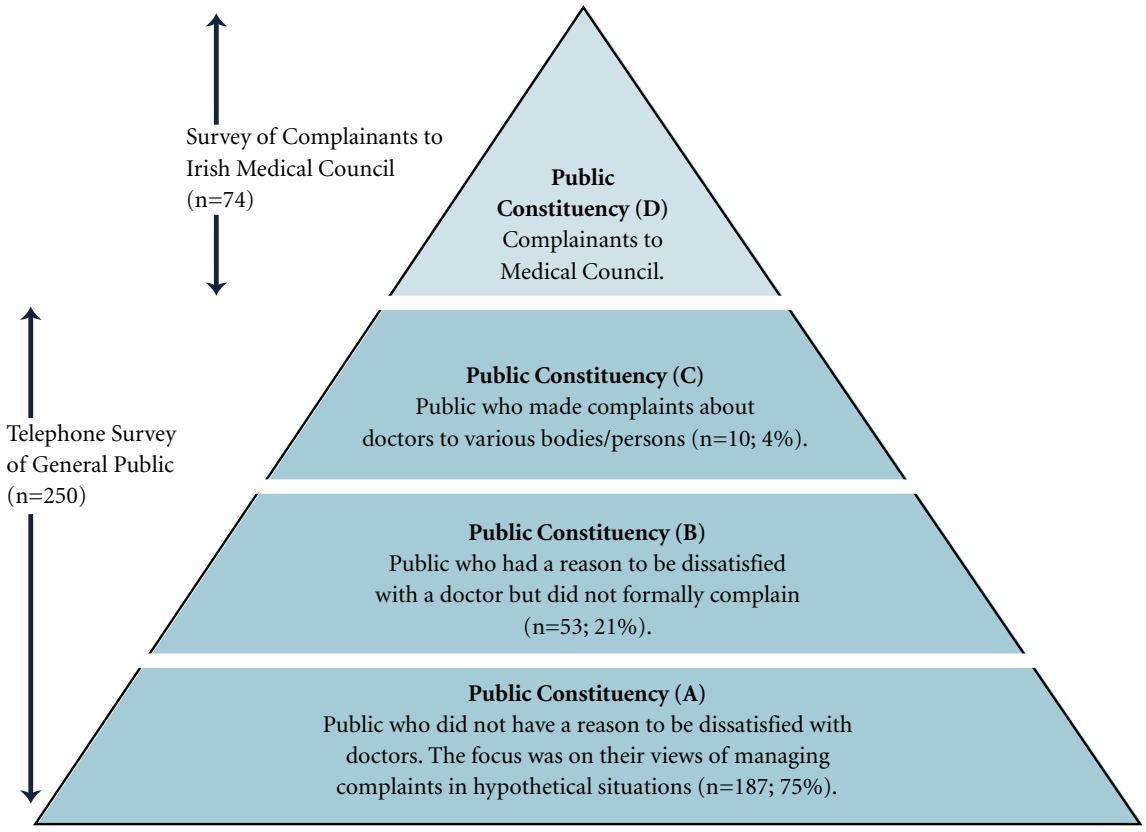
There is a growing demand at all levels of Irish society for greater transparency and accountability, and in government and professional services it is widely understood that systems for dealing with complaints must continue to evolve. The Irish healthcare system is undergoing rapid change and new legislation is being implemented to recognise the rights of the public and to improve the regulation of the health professions. The new Medical Practitioners Act, which is due in late 2006, is expected to increase the powers of the Irish Medical Council in regulating the medical profession. The Health Act 2004, when fully implemented, will provide a statutory basis for complaints made to hospital authorities (excluding those solely related to clinical judgement) and will standardise complaint handling procedures across all hospitals. In the context of these developments, the Irish Medical Council commissioned a series of surveys to identify how its role and function can develop in congruence with the needs of its key stakeholders: the medical profession and the general public.

1.2 Method

The research consisted of four surveys of key public and professional stakeholders:

1. *National Hospitals Survey* – postal survey regarding quantity and types of patient complaints (35 hospitals participated).
2. *Telephone Survey of the General Public* – regarding satisfaction with doctors and knowledge of complaints procedures (250 participated in this pilot study)
3. *Survey of Complainants to the Irish Medical Council* – telephone and postal survey of the views of persons who complained to the Irish Medical Council (74 participants).
4. *Survey of Doctors Complained to the Irish Medical Council* – postal survey of the views of doctors about whom complaints were made to the Irish Medical Council (117 participants).

Figure 1: Public stakeholders who participated in surveys



1.3 Integrated Findings

The main findings of the research were:

- **There was a high level of satisfaction with doctors.** Eighty-four per cent of the public surveyed were satisfied overall with the care they received from doctors over the past five years. Complaints about doctors to hospital authorities constituted a minority (15%) of complaints received about hospital services.
- **While, overall, there was high level of satisfaction with doctors, 25% of the public surveyed reported that they did have *a reason* for being dissatisfied with a doctor over the previous five year period.** These mainly concerned consumer issues such as high cost and poor value for money, poor communication/inter-personal skills and a variety of clinical care issues.
- **Dissatisfied patients were unlikely to make a complaint about a doctor.** Only 16% of the public who had a cause to be dissatisfied had complained. Not knowing how to complain, to whom to complain or feeling that complaining was not worthwhile were the most common reasons given.
- **There was a low level of public awareness of the agencies responsible for dealing with complaints about doctors.** Fifty-five per cent of the public surveyed had heard of the Irish Medical Council. Of these, 42% were not aware of any of its functions. Furthermore, at the time of making the complaint, 82% of complainants to the Irish Medical Council were unaware of alternative channels for making complaints about doctors. There was also a low level of hospital referrals of complaints (0.3%) to the Irish Medical Council. The lack of awareness may have been linked to an absence of an inter-agency and hierarchical approach to dealing with complaints.
- **Complaints about doctors were mainly about communication and clinical care issues.** Complaints about unprofessional behaviour rarely featured among complaints but were more common among complaints to the Irish Medical Council. Doctors viewed unrealistic expectations of patients and patient anger towards them as common factors in the genesis of complaints.
- **Complainants to the Irish Medical Council and doctors complained against showed a high level of agreement about the changes required to make regulation more effective and fair to both parties.** These changes included:
  - **Increased transparency:** Both complainants and doctors recommended increased transparency. They felt the Irish Medical Council should provide explanations for decisions not to proceed to fitness to practise inquiries. This recommendation arose from complainants' needs to have complaints adjudicated and to receive information about how they were investigated. It also arose from doctors' needs to feel vindicated from accusations of wrong-doing. Complainants wanted more information at the beginning of the complaints process about what constitutes a *prima facie case* (the criteria required for an investigation and sworn legal inquiry into a complaint). Doctors for example, would like to have known statistics on the number of complaints that proceed to fitness to practise inquiries each year.
  - **Improved communication:** Both complainants and doctors would prefer to have received personalised communication from the Irish Medical Council rather than standardised legally-formulated letters. Complainants found it difficult to communicate the complexities of their complaints in written form and felt that verbal communication would have facilitated the proper investigation of their complaints. Doctors felt that a personal, individualised communication at initiation and closure of the process would be less fear-inducing and would acknowledge the level of stress and anxiety a complaint causes for a doctor.

- **A graded response to complaints:** Both complainants and doctors felt that examining all complaints under the charge of professional misconduct was inappropriate. Described by one complainant as "a doctor breaking a red light and being charged under the Murder Act", complainants felt that this approach made doctors accountable only for complaints about gross medical errors, which are in the minority. From the point of view of doctors, those who considered their complaints to be trivial or vexatious, felt it was unfair to be subjected to a stressful and lengthy statutory process when, in their opinion, it was obvious that a fitness to practise inquiry was not necessary. Both sets of respondents were open to informally resolving complaints in appropriate cases.
- **The need to modernise medical regulation:** Complainants and doctors agreed that transparency and accountability are required for regulation to be effective. Their recommendations focused on how to improve the complaints procedure and how it is experienced. Both predominantly viewed holding fitness to practise inquiries in public as problematic. Most supported public involvement in the regulatory process (97% of complainants and 75% of doctors). However, the issue of public representation was not a priority for improving the complaints procedure – it accounted for only 4% of complainant recommendations. The survey of the general public showed that the majority (95%) favoured a system of more public involvement than at present (currently at least four out of 25 members are non-medical). However, most (82%) wanted this to be in conjunction with medical professionals in somewhat increased (40%) or in approximately equal numbers (42%) (see Section 3.4.5).

- **There were potential areas of conflict between complainants' and doctors' views.** These present a challenge to the Irish Medical Council in leading the multi-stakeholder regulatory environment. Issues included:
  - **Producing effective outcomes from the complaints process:** Numerous findings showed the complexities involved in ensuring that the outcomes of the complaints process are effective and worthwhile. For example, many complainants (81%) were dissatisfied with the outcome of the complaints process. Amongst other outcomes, they wanted the doctor to receive a warning and to be assured that the unsatisfactory practise would not be repeated or continued. Two thirds reported that they did not achieve any of the outcomes they wanted. In contrast, most doctors (83%) were satisfied with the outcome of the process. However, 20% were dissatisfied with how the Irish Medical Council handled the complaint because they felt they processed trivial or vexatious complaints against them. Doctors felt such complaints should be screened. Some suggested there should be an avenue for doctors to gain redress for having false complaints made against them. Two thirds of doctors said they were more likely to practise defensive medicine as a result of the complaint. These are challenging issues. However they may be offset by more open communication, transparency and graded responses to complaints.
  - **Maintaining positive perceptions of the Irish Medical Council as a regulatory body:** The period surrounding a complaint was stressful for both complainants and doctors. At the end of the complaints process, complainants in general had negative perceptions of the Irish Medical Council. They viewed the Irish Medical Council as an organisation that protects doctors. This was mainly because of the lack of transparency and communication and the high threshold set for reaching a level of misconduct. Conversely and although the experience of receiving the complaint was largely negative, doctors in general retained positive perceptions of the Irish Medical Council. This was probably because the outcomes of most complaints were satisfactory to doctors (i.e. in approximately nine out of ten cases there was a decision not to proceed to a fitness to practise inquiry). Clearly, revision of the complaints process is required to address the discrepancies in stakeholder experiences.
  - **Ensuring that medical regulation (professional led or otherwise) does not involve a trade off between the public's and doctors' rights.** A system that is transparent, accountable and impartial is required by all stakeholders. The potential areas of conflict may be overcome if the complaints procedure is appropriately modernised and the conclusions outlined next acted upon.

1.4 Conclusions

Conclusion One: A standardised inter-agency approach to dealing with complaints should be developed. An inter-agency working group should be established, consisting of the Irish Medical Council, Health Services Executive, Department of Health and Children and the Office of the Ombudsman, to identify areas where co-operation is required for effective regulation. Priority areas of the working group would be to:

- Develop a model of effective inter-agency co-operation to ensure that the most appropriate agencies deal with particular types of complaints.
- Ensure that there is inter-agency co-operation in implementing learning gained from the outcomes of complaints processes. For example, the Irish Medical Council should have the authority to make binding recommendations to hospitals following evidence of serious systems failures in investigating a complaint about a doctor.
- Standardise complaints handling procedures across agencies in accordance with best practice. According to the Government White Paper, Regulating Better (2004), "legislation in linked or connected areas will be consistent, and kept up to date". Hence, the progressive elements of the framework for the new hospitals complaints system set out in the Health Act 2004 should be incorporated into the Irish Medical Council complaints procedure under the new Medical Practitioners Act. For example, the Irish Medical Council complaints procedure should give reasons for decisions not to further investigate a complaint, make recommendations, resolve complaints on an informal basis if requested and have a review procedure for persons dissatisfied with the outcome of their complaint.
- Develop a strategy to inform patients of their rights under the new complaints system and clarify how complaints about clinical care will be dealt with.

Conclusion Two: Complaints should be investigated in a transparent manner in proportion to the issue of concern. Fundamentally, this will involve a review of the purpose of the Irish Medical Council's fitness to practise functions. The following issues should be considered:

- Implement a screening procedure so that complaints of a less serious nature or inappropriate to the Irish Medical Council remit can be dealt with locally e.g. at hospital level.
- Grade responses to complaints by examining them under the charge of professional misconduct and a less serious charge, perhaps entitled poor professional performance. This would enable those who complain about issues that rarely reach the criteria for professional misconduct (e.g. misdiagnosis/lack of diagnosis, poor treatment, poor communication and interpersonal skills) to have their complaints judged in proportion to the issue of concern.
- Develop clear and accessible definitions of what constitutes professional misconduct and the less serious charge. The literature shows that this will be a complex task as definitions depend on subjective judgement (Thomspon, 2005). However, definitions are necessary to ensure all complaints are treated equally and not on an ad hoc basis.
- Develop protocols to show the types of complaints that should be treated under each charge and procedures to deal with complaints at each of these levels. In appropriate cases, the procedures should provide opportunities for complaints to be resolved informally, for example, through a meeting with the complainant, doctor and Irish Medical Council representative. The procedures should strongly consider the need for interview of both parties, particularly when the complaint relates to serious clinical care issues.
- Adjudicate all complaints that are examined under the procedures. Provide complainants and doctors with an explanation as to why a complaint did or did not meet the criteria for professional misconduct or poor professional performance. A statement that they did not meet the criteria for either charge is not sufficient. There should be an appeals process for those dissatisfied with the outcome.
- Ensure effective outcomes arise from the complaints process. Outcomes, in proven cases, should address what the complainant wanted to happen as a result of complaining. These should not be unfairly punitive towards doctors. Complainants should be informed of the outcome.

Conclusion Three: A proactive communications strategy should be developed aimed at meeting the information needs of the Council's key stakeholders. Priority areas of the communications strategy may be to:

- Inform the *General Public* about the role of the Irish Medical Council and of the particular purpose of its fitness to practise functions. A mission statement regarding fitness to practise should be developed and agreed.
- Increase the awareness of *Hospital Managers* of the circumstances in which referral of complaints to the Irish Medical Council is appropriate.
- Proactively engage with *Complainants.* Have a procedure for asking complainants what they would like to happen as a result of their complaint and inform complainants of what does and does not constitute a prima facie case through use of examples and case studies.
- Proactively engage with *Doctors Complained.* Have a procedure for asking doctors if they would like to avail of emotional or practice-related supports during the time which the complaint is in progress. Supports could be provided by an outside agency, independent of the Irish Medical Council. Develop an information handout about how to cope with receiving a complaint.

Conclusion Four: The Irish Medical Council should promote the development of excellent communication skills and high levels of interpersonal effectiveness among all doctors.

- As part of the Irish Medical Council's role to monitor standards in medical practice and education, there is a need to ensure that training deals comprehensively with communication and interpersonal skills both at undergraduate and postgraduate levels. Part of this process may be to develop an explicit model of the non-clinical competencies expected of doctors including methods of teaching and assessing these competencies.

Conclusion Five: Rather than relying solely on complaints to identify potential problems, a proactive system for monitoring medical practice should be developed.

- The Irish Medical Council should engage with the Department of Health and Children and Health Services Executive to establish a systematic mechanism for monitoring the clinical performance of doctors. National outcomes data for medical procedures and interventions are needed to provide safeguards and to help identify and remediate doctors who may be functioning below appropriate standards. Such a national structure is essential to support the regulatory role of the Irish Medical Council and its proposed competence assurance structures.
- A national medical outcomes database could be used to monitor the performance of hospitals in addition to doctors. National statistics could be used so that particular hospitals or doctors who have a greater number of adverse outcomes than the norm can be identified and appropriate intervention taken.

Conclusion Six: In order to monitor the profile of complaints over time, routine complaints statistics at hospital and national level should be collated.

- A system is needed to standardise complaints recording procedures and document the type of complaint and the type of staff member complained of. An audit of such complaints should be discussed at an annual medical forum. This is to ensure complaints feedback into service provision and foster learning among doctors.

Conclusion Seven: Future research should be focused on patients' experiences of the new hospital complaints procedures when these have been established and settled, and on complainant and doctor experiences of the Irish Medical Council complaints procedures under the new Medical Practitioners Act.

2. National Hospitals Survey

2.1 Background

This survey aimed to document the nature and quantity of complaints made to hospitals, particularly those about doctors. This information has never been systematically identified to date. The survey sought to identify over a five year period (August 2000 to 2005);

- The number of patient complaints about any aspect of hospital care
- The number and types of patient complaints about doctors
- The level of overlap between the Irish Medical Council and hospitals in dealing with complaints.

2.2 Method

- The survey was developed on the basis of an international literature review and in consultation with Irish Medical Council personnel. The questionnaire was sent as an anonymous survey to the Chief Executive Officers/Hospital Managers of all general hospitals (n=51) in the Republic of Ireland. Additional psychiatric and specialist (e.g. orthopaedic and geriatric) hospitals surveyed (n=29) were excluded from the main analysis since only a small number of these hospitals responded. Those responding received a very small number of complaints.

2.3 Profile of Participants

- Thirty-five general hospitals took part in the study including, ten large/supra-regional, ten regional and 15 local hospitals. With reminders, a 69% response rate was achieved (Table 1).

Table 1: Response rates to *Hospital Survey*

	Hospitals Invited N	Hospitals Responding N	Response Rate %
All	51	35	69
HSE	32	19	59
Voluntary Public	15	13	87
Private	4	3	75

- For a postal survey, on such a sensitive topic, this high participation rate means that the findings can be taken as broadly representative of general hospitals in Ireland. Furthermore, the high number of responses from larger hospitals means the data collected should reflect those hospitals employing most doctors and seeing most patients. The data collected can thus provide important and previously unavailable insights on the extent and nature of complaints and of how they are managed.

2.4 Results

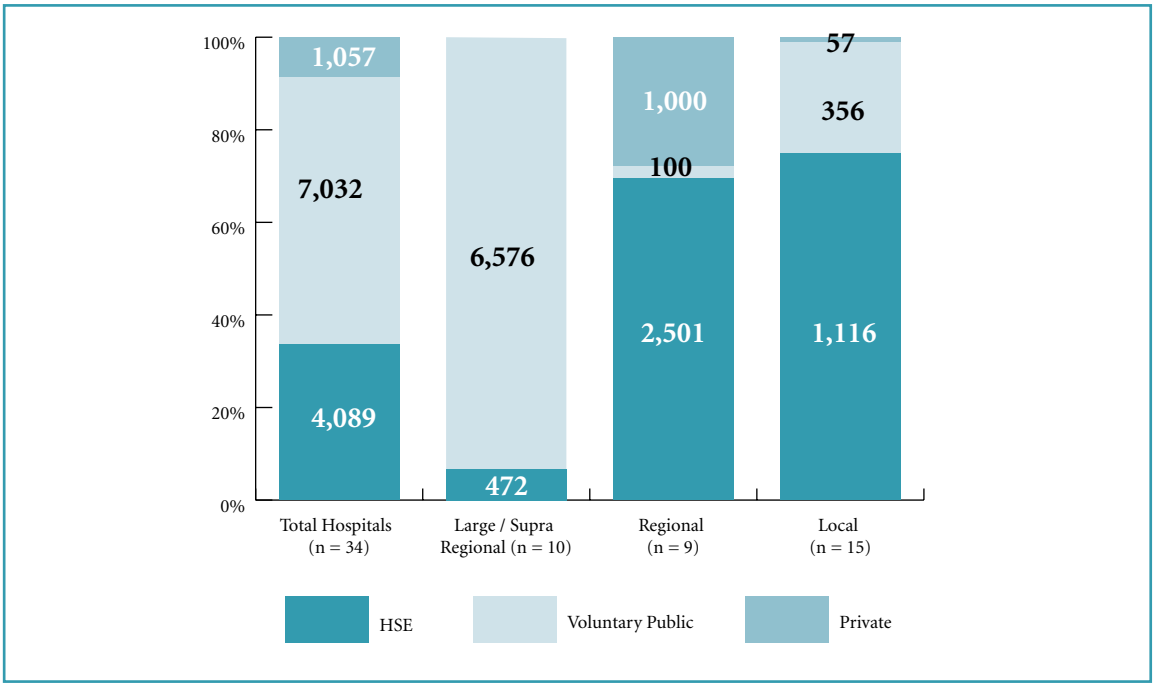
Five key findings were identified.

2.4.1 Patient complaints about hospital care

Key Finding One: Across 34 hospitals, there were 12,178 patient complaints about any aspect of hospital care over the five years.

- Thirty-four of the 35 hospitals indicated that 12,178 patient complaints were received about any aspect of hospital care over the five year period August 2000-2005 (Figure 2). The figure represents a conservative estimate of the number of complaints as five of the 34 hospitals did not report complaint statistics for the full five years.

Figure 2: Number of complaints about hospital care by size and type of hospital



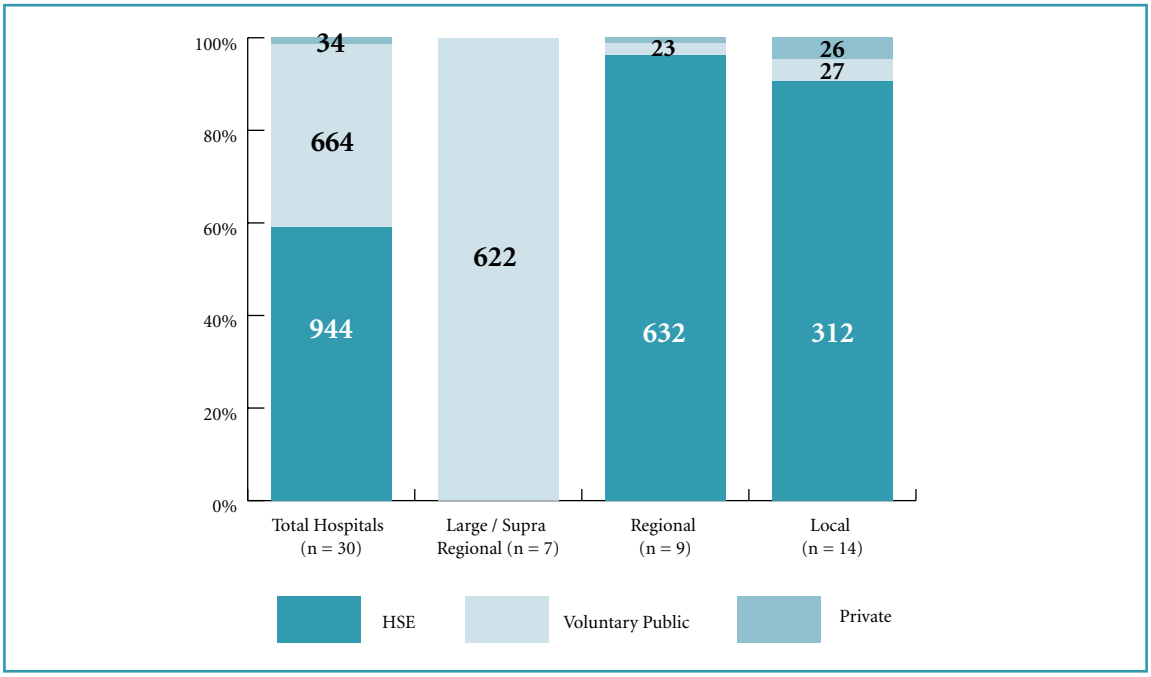
- Over half of the complaints (n=7,048; 58%) were in large/supra-regional hospitals, almost a third (n=3,601; 30%) were in regional hospitals and 12% (n=1,529) were in local hospitals. Within each of these categorisations of hospital, the reported number of complaints varied considerably.
- Over half of complaints (n=7,032; 58%) were in voluntary public hospitals (n=12), 33% (n=4,089) were in HSE hospitals (n=19) and 9% (n=1,057) were in private hospitals (n=3).

2.4.2 Patient complaints about doctors

Key Finding Two: Across 30 hospitals, there were a total of 1,642 patient complaints about medical doctors.

- Thirty of the 35 hospitals reported a total of 1,642 patient complaints about doctors over the five year period (Figure 3). Again, this is a conservative estimate as five of the 30 hospitals did not report complaint statistics for the full five years.

Figure 3: Number of complaints about doctors by size and type of hospital



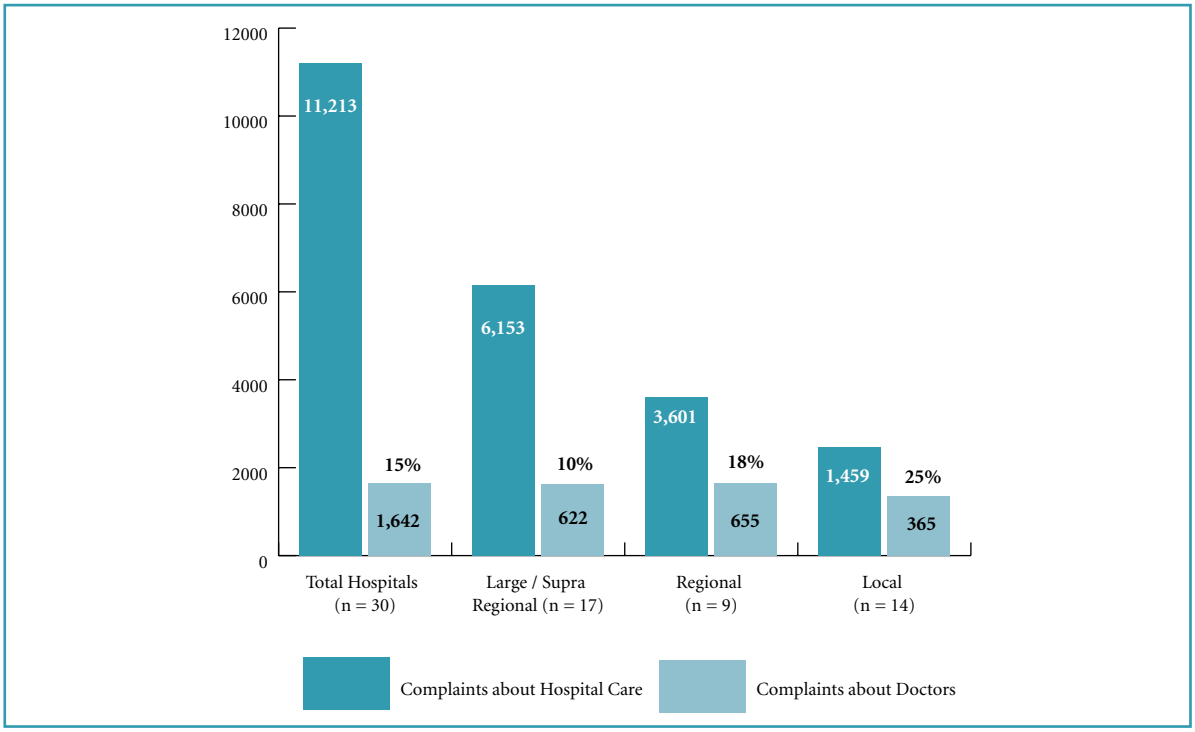
- Thirty-eight per cent of these complaints (n=622) were in large/supra-regional hospitals, 40% (n=655) were in regional hospitals and 22% (n= 365) were in local hospitals.
- Over half (58%; n=944) of complaints were in HSE hospitals (n=16), 40% (n=664) were in voluntary public hospitals (n=11) and 2% (n=34) were in private hospitals (n=3).

2.4.3 Proportion of hospital complaints about doctors

Key Finding Three: Fifteen per cent of all complaints to hospital authorities were about doctors. Smaller hospitals had a higher proportion of complaints about doctors.

- Over the five year period, 15% (n=1, 642) of complaints (n=11, 213)[1] to general hospitals (n=30) were about doctors (Figure 4).
- The proportion of complaints about doctors was lowest in large-supra regional hospitals (10%) and highest in local hospitals (25%). Eighteen per cent of complaints to regional hospitals were about doctors.

Figure 4: Number of complaints about doctors and other aspects of hospital care by hospital size



2.4.4 Types of patient complaints about doctors

Key Finding Four: Patient complaints about doctors mainly concerned clinical care and communication issues.

- Of the 30 hospitals that indicated the number of complaints about doctors (n=1, 642), 27 categorised the types of complaints (n=1, 394) made (Table 2).
- Patient complaints about doctors were predominantly about clinical care (51%) and communication (47%) issues. Unprofessional behaviour complaints (2%) were rare.
- Poor or lack of communication (23%), inconsiderate/rude (21%), misdiagnosis/lack of diagnosis (21%) and incompetence/negligence (18%) together accounted for 83% of all complaints about doctors.
- Although they rarely occurred, the most common types of unprofessional behaviour complaints concerned refusal to treat (0.8%) and failure to refer (1.2%).

Footnote [1]: Of the 34 hospitals who reported the number of complaints about any aspect of hospital care, 30 reported the numbers of complaints about doctors in particular. The 11, 213 complaints about hospital care in these 30 hospitals form the basis from which the proportion of complaints about doctors was calculated.

Table 2: Types of patient complaints about doctors over past five years

Types of Complaints:	Hospitals with complaint type		Complaints	% of all complaints
	N	%	N	%
1) Clinical Care				
Incompetence/negligence	12	44	247	17.7
Misdiagnosis/lack of diagnosis	20	74	295	21.2
Adverse outcome	10	37	45	3.2
Lack of hygiene	7	26	17	1.2
Clinical care complaints uncategorised	3	11	104	7.5
Total	**23**	**85**	**708**	**50.8**
2) Communication				
Inconsiderate/rude	21	78	295	21.2
Poor or lack of communication	17	63	314	22.5
Prejudice	3	11	6	0.4
Communication complaints uncategorised	2	7	39	2.8
Total	**25**	**93**	**654**	**46.9**
3) Unprofessional behaviour				
Refusal to treat	8	30	11	0.8
Failure to refer	8	30	17	1.2
Physical or sexual abuse	2	7	2	0.1
Breach of confidence	1	4	1	0.1
Fraud	0	0	0	0.0
Personal behaviour complaints uncategorised	1	4	1	0.1
Total	**13**	**48**	**32**	**2.3**
Total Hospitals/Complaints	**27**	**100**	**1, 394**	**100**

2.4.5 Level of overlap between Hospitals and Irish Medical Council in dealing with complaints

Key Finding Five: **Hospitals predominantly used their own complaints procedures in dealing with complaints about doctors. Referral of complaints to the Irish Medical Council was rare.**

- Over the five year period, 3 of the 35 hospitals (9%) indicated they referred a total of five complaints to the Irish Medical Council. This represented 0.3% of all complaints (n=1, 642).
- Of those who did not refer complaints (n=32), five indicated that referral had been considered. Some replies indicated that patients may have referred complaints themselves.
- Of the 35 hospitals, 25 noted enablers and barriers to referral. Of these, most identified the Irish Medical Council acting to maintain standards in medicine (n=23) and to protect the public interest (n=14) as enabling factors. Barriers included that referral damages the relationship between hospital management and medical staff (n=12), that medical staff are reluctant to have complaints referred (n=10) and that hospital managers are unaware of the circumstances in which referral of complaints is appropriate (n=10).
- Qualitative data showed that the reasons for not referring complaints included the need to be fair to doctors; the legalistic and officious nature of the Irish Medical Council complaints process; the absence of criteria on types of complaints to refer; and views that referral is warranted for very severe complaints only.

2.5 Discussion

Complaints about doctors (15%) to hospital authorities constituted a minority of complaints received about hospital services.

The number of complaints (n=1, 642) made to hospital authorities about doctors over the past five years was very small. It was estimated that they represented less than 0.03% of 5.7 million doctor-patient interactions in these hospitals (n=30) over the five year period. These figures fit with recent positive statistics for overall satisfaction with hospitals. The report, *Patients View (2004)*, a survey of hospital users by the Irish Society for Quality and Safety in Healthcare (ISQSH), showed that the majority of patients were confident about the treatments they received (94%) and were satisfied with services (93%). Furthermore, the complaints counted were allegations. This survey did not ask about the numbers substantiated. However, the complaints noted represent formal (written) complaints and previous research has shown that patients have a low tendency to complain when they experience dissatisfaction (the survey of the general public addresses this issue further).

In smaller hospitals, a larger proportion of complaints to hospital authorities were about doctors.

The proportion of complaints about doctors was 25% in local hospitals compared to 18% in regional hospitals and 10% in large/supra-regional hospitals. The reasons for this pattern are unclear. It may be that it is easier for patients to complain in smaller hospitals or for smaller hospitals to monitor and record complaints. It could be a reflection upon the organisation of hospital services, the resources in place or the demands placed upon doctors.

Clinical care (51%) and poor or inadequate communication (47%) accounted for the majority of complaints about doctors. Complaints about unprofessional behaviour were rare.

The finding that clinical care comprised a significant number of complaints (51%) was not unexpected. The finding that the quantity of complaints about communication issues almost equalled those about clinical care may cause some concern. The ISQSH Report *Patients View* (2004) stated that "the communication practices of staff, including the adequacy and clarity of information given to patients in relation to diagnosis and care" was an area requiring improvement. The practices they identified, in order of priority included (1) communication of side effects of drugs, (2) accessibility of staff to patients, (3) patient involvement in decision-making and (4) communication of diagnosis.

Hospitals predominantly used their own complaints procedures to deal with complaints about doctors.

There was little overlap between the Irish Medical Council and hospitals in dealing with complaints about doctors. Hospitals rarely referred or considered referring complaints to the Irish Medical Council - only 0.3% of all complaints (n=5) about doctors were referred. This practice is as advised - that insofar as possible the best place to resolve complaints is at local level (Office of the Ombudsman, 2006). However, some hospitals did identify barriers to referral which should be considered as part of the Irish Medical Council's quality improvement process.

The absence of interaction between hospitals and the Irish Medical Council in dealing with complaints has implications for the framework for the new hospitals complaints system, set out in the Health Act 2004. While yet to be implemented, one "potential fatal flaw in the complaints mechanism" is the exclusion of patients from the statutory right to complain to hospitals about issues relating solely to the exercise of clinical judgement (Mathuna et al, 2004). This means that patients who are dissatisfied with a doctor's clinical performance will have to make a complaint to the State Claims Agency or the Irish Medical Council. If hospital managers are no longer entitled to deal with complaints about clinical care issues, problems will not be dealt with close to source, the number of complaints dealt with by the Irish Medical Council will increase and the responsibilities of hospitals in the domain of clinical performance will be de-emphasised. Hence, there is a need to clarify how these complaints will be dealt in the new complaints system.

The need for a standardised and hierarchical inter-agency approach to dealing with complaints.
There are now a number of national agencies dealing with complaints about doctors. These include the Irish Medical Council, the Ombudsman and complaints management systems available in hospitals and the Health Services Executive. These do so in isolation from one another. The development of the new complaints system presents an opportunity to standardise complaints procedures across agencies and to formulate approaches to inter-agency co-operation. The types of health care complaints appropriate to hospital authorities, the Irish Medical Council and the Ombudsman or a combination of these, should be clear to patients and health care managers. Consistency and transparency across bodies dealing with complaints has been identified as essential in achieving effective regulation (Government White Paper: Regulating Better).

2.6 Conclusion

This study has quantified the number of complaints made about doctors to hospitals in Ireland over a five year period. Complaints about doctors represented a minority of overall complaints to hospitals. They predominantly concerned clinical care and communication issues. There were few patient complaints about unprofessional behaviour. Hospitals rarely referred complaints to the Irish Medical Council. Thus current practice differs significantly from that envisaged in the new legislative framework. There is a need to promote transparent, efficient and effective regulation through a standardised inter-agency approach.

3 National Telephone Survey of Public Perspectives

3.1 Background

The Irish Medical Council commissioned this pilot study of the general public to assess the level of public satisfaction with medical doctors and to evaluate awareness of, and willingness to use, complaints procedures.

The specific objectives of the study were to profile:

- Satisfaction with care from medical doctors in Ireland
- Reasons for any dissatisfaction with doctors
- Willingness to complain after a real or hypothetical unsatisfactory experience and;
  - Persons or organisations to whom the public would complain
  - Outcomes the public would want from complaining
  - Reasons for not making a complaint
  - Approaches to addressing dissatisfaction other than, or in addition to, making a complaint.
- Awareness and knowledge of the role and function of the Irish Medical Council
- Views of the type of regulation required for the medical profession
- Events or experiences that may have influenced views of the Irish Medical Council over the past ten years.

3.2 Method

- Since no prior models of a study on these issues existed in Ireland, a pilot study formed a useful opportunity to test the concepts and questions developed for applicability, while cautioning that the sample size was not adequate enough to draw definite conclusions.
- The target population was a representative sample (n=250) of the general public as indicated by the 2002 Population Census. It was stratified to be representative of the population by broad region, gender, age group and broad PES (principal economic status). Stratification was imposed at the point of interview to ensure selected respondents matched the socio-demographic structure of the population at large.
- A random sample of telephone numbers was obtained from the Economic and Social Research Institute who compiled these using the GeoDirectory database. As is the norm in telephone surveys, the numbers were selected on a random digit dialling basis. The process involved selecting area codes across a range of geographical clusters and then identifying possible 'stems'. This process allowed the widest coverage of telephone numbers by enabling contact with ex-directory numbers and new numbers not listed in phone directories.
- Researchers developed the questionnaire to fulfil the aims of the study. The telephone interview methodology was chosen as it has been previously used with good response rates in health services research in Ireland. Data collection was carried out by two researchers during February and March 2006. Only those aged 18 years and older were invited to participate. The survey took approximately 10 to 15 minutes to complete. Data was analysed using the statistical software package SPSS.

3.3 Profile of Participants

- Two hundred and fifty randomly selected adults living in Ireland took part in the study, representing a 63% response rate from those invited (n=394).
- The selection of the sample ensured that there was an approximately equal number of men (n=123) and women (n=127) and of those aged 18-44 (n=126) and 45 years and over (n=124). The sample matched the demographic profile of the general population in terms of geographical region and personal economic status (PES). For example, 30% of the sample were located in Dublin, 27% were located in the Border Midland Western (BMW) area and 43% were located in the Rest of the Country. Over half (59%) were in employment, while 41% were not.

3.4 Results

Seven key findings were identified.

3.4.1 Satisfaction with doctors

Key Finding 1: **There was a very high level of satisfaction with the care received from medical doctors over the past five years.**

- Over the past five years, 84% (n=208) were satisfied with the care they received from medical doctors, 6% (n=16) were neither satisfied nor dissatisfied and 10% (n=24) were dissatisfied (Table 3).

Table 3: Satisfaction with care from medical doctors over the past five years by gender and age group

	Satisfied		Neither satisfied nor dissatisfied		Dissatisfied	
	N	%	N	%	N	%
Overall (n=248)	**208**	**84**	**16**	**6**	**24**	**10**
18-44 years (n=124)	99	80	13	10	12	10
45 years plus (n=124)	109	88	3	2	12	10
Men (n=122)	**100**	**82**	**8**	**7**	**14**	**11**
18-44 years (n=61)	49	80	5	8	7	11
45 years plus (n=61)	51	84	3	5	7	11
Women (n=126)	**108**	**86**	**8**	**6**	**10**	**8**
18-44 years (n=63)	50	79	8	13	5	8
45 years plus (n=63)	58	92	0	0	5	8

- There were high levels of satisfaction among men (82%) and women (86%), among those aged 18 to 44 (80%) and 45 years and over (88%), and among those living in Dublin (86%), the BMW area (89%) and in the Rest of the Country (80%). There was a general pattern illustrating that those aged 45 years and over were slightly more satisfied than those aged 18 to 44 years.

3.4.2 Reasons for dissatisfaction with doctors

Key Finding 2: **While 84% were satisfied overall, 25% reported they had *a reason* to be dissatisfied with a doctor over the past five years. The main reasons related to (1) consumer issues in health care, (2) doctors' inter-personal and communication skills and (3) clinical care issues.**

- Of the 250 respondents, 25% (n=63) stated that they had *a reason* to be dissatisfied with a doctor over the past five years. The types of doctors dissatisfied with were GPs (49%), hospital consultants (43%), non-consultant hospital doctors (2%) and other types of doctors (6%). The highest prevalence of reasons to be dissatisfied were in the Rest of the Country (30%), followed by Dublin (27%), and the BMW area (16%). There were few age or gender differences in proportions likely to have had a reason to be dissatisfied (Table 4).

Table 4: Respondents who had ***a reason*** to be dissatisfied with a doctor by gender, age group and geographical region

	Had a reason to be dissatisfied	
	N	%
Overall (n=250):	63	25
Gender:		
Men (n=123)	33	27
Women (n=127)	30	24
Age Group:		
18-44 years (n=126)	35	28
45 years plus (n=124)	28	23
Region:		
Dublin (n=75)	20	27
Border Midland Western (n=67)	11	16
Rest of the Country (n=108)	32	30

- Respondents were asked to describe the reasons why they were dissatisfied and these were analysed to form themes (Table 5). Content analysis showed there were seventy reasons for respondent dissatisfaction.
- Over one third of reasons (36%) related to consumer issues in health care – high cost, poor value for money and the lack of availability of medical services.
- Thirty per cent related to dissatisfaction with doctors' inter-personal skills including rudeness, poor communication and a lack of empathy.
- Over one quarter (27%) related to clinical care issues, for example a misdiagnosis/lack of diagnosis or the prescription of ineffective medication.

Table 5: Themes illustrating respondent dissatisfaction with doctors

Themes:	Reasons for Dissatisfaction	
	N	%
1. Consumer issues: high cost, poor value for money and lack of availability of medical services	25	36
2. Poor inter-personal and communication skills	21	30
3. Clinical care issues	19	27
4. Doctors not up-to-date in practices	3	4
5. Loss of files	1	1
6. Breach of confidentiality	1	1

- The content analysis suggested that the public may be in some instances hold doctors responsible for what are *in part* failures of the health care system, for example the shortage of medical personnel has resulted in an excess demand on existing doctors' time and a lack of availability of some medical services. Replies also indicated that high standards of proficiency in technical and inter-personal skills are expected among doctors and that dissatisfaction arises when the limitations of medicine are not overcome.

3.4.3 Willingness to complain

Key Finding Three: Sixteen per cent of those who experienced dissatisfaction made a complaint at local level.

- Of the 63 respondents reporting dissatisfaction, 16% (n=10) made a complaint, 25% (n=16) considered making a complaint but did not and 59% (n=37) did not consider making a complaint. Those aged 45 years and over were somewhat (10%) more likely to have made a complaint than those aged 18-44. Half (n=5) complained to the doctor concerned and the remainder complained to other health professionals (n=3) or hospital management (n=2).
- Fifty-three respondents (84%) did not complain. Not knowing to whom to complain (40%), how to complain (34%) or feeling that there was no point (36%) were the most common reasons. Others were reluctant to get the doctor in trouble (26%) or were concerned about damaging their relationship with the doctor (23%). Numerous miscellaneous reasons (45%) were cited, for example a lack of time to complain and perceptions that the dissatisfaction was not serious enough to warrant a complaint.

Key Finding Four: There was a greater willingness to complain following consideration of hypothetical situations. Just under half of those who said they would complain, did not know to whom they could complain.

- The majority of respondents (n=187), those who did not have a reason to be dissatisfied, were presented with two hypothetical scenarios which might cause them to be dissatisfied. They were asked what they would do in each situation. The scenarios and the action they would take are summarised next.
- Scenario One: *Although requested, your local GP did not attend a patient with diabetes (your relative) who had symptoms of dizziness and repeated vomiting, late on a Friday evening. The following day the patient was hospitalised in intensive care for two weeks.*
- Eighty-one per cent said they would complain about the GP in this scenario, which involved a refusal to treat and an adverse outcome.
- Scenario Two: *Contrary to your wishes, a hospital consultant judged that your relative did not require a head x-ray after falling down a stairs and sent him/her home. The patient was well the next day and had maintained good health.*
- Respondents were less willing to complain about the hospital consultant in this scenario (where there was refusal to treat but no adverse outcome). Sixty-three per cent said they would make a complaint about the doctor, 36% said they would not and 1% did not know.

Persons/organisations to whom respondents would complain

- In both cases, approximately 44% did not know to whom they would complain. Respondents were most likely to complain about the GP to the Irish Medical Council (20%) or the Health Boards/Health Services Executive (14%) and they were most likely to complain the hospital consultant to hospital management (31%). Approximately 44% said if they did not get what they wanted by complaining, they would take the complaint further.

Outcomes wanted from complaining

- In both cases, most (87% to 95%) wanted the doctor to learn from his or her mistake, to prevent an unsatisfactory practise being continued or repeated, to have their grievance acknowledged, to receive an explanation from the doctor and to have their difficulty with the doctor sorted out. Over two-thirds wanted to receive an apology and over half wanted the doctor to receive a warning.

Reasons for not complaining

- Nineteen per cent of respondents would not complain about the *GP*. Lack of knowledge about how to complain (37%), to whom to complain (37%), reluctance to get the doctor in trouble (34%) and feeling that complaining was not worthwhile (34%) formed the main reasons. A further 23% would not have complained because they would not have expected the doctor to attend to the patient so late at night.
- Thirty-six per cent of respondents (n=68) would not complain about the *hospital consultant*. Of these, half (n=34) reported that they would have trusted the doctor's judgement and felt a complaint was not necessary. Approximately one quarter would not know to whom to complain (28%), how to complain (24%) or think there was no point (24%).

Means of addressing dissatisfaction other than complaining

- In Scenario One, 71% said they would take other courses of action to address their concerns, in addition to or instead of complaining. Most respondents said they would change GP. Others, for example, said they would report their story to the media, "bad mouth the doctor" or seek legal advice.
- In Scenario Two, only 5% said they would take other courses of action, for example complain about the hospital to other members of the public or contact a local politician.

3.4.4 Awareness of organisations responsible for complaints

Key Finding Five: Approximately two thirds of respondents were aware of the main organisations that deal with complaints about doctors and over half had heard of the Irish Medical Council prior to the study.

- Approximately two thirds of respondents were aware that hospital management (68%), the health boards/ HSE (65%) and the Irish Medical Council (63%) deal with complaints about doctors. However, only 24%, 14% and 15% of respondents were confident that that this was definitely the case. It is difficult to assess awareness regarding specific organisations in such a survey situation without prompting confirmatory answers which would not have been forthcoming in an open-ended situation.
- Fifty-five per cent (n=136) of respondents had heard of the Irish Medical Council prior to the study (54% of men and 53% of women, 50% of those aged 18 to 44 and 60% of those aged 45 years and over). The majority were aware of the organisation through media reports on television or in newspapers (85%). Relatively few had heard of the Irish Medical Council through health professionals (13%), Irish Medical Council advertising (8%) or from working in the health care sector (3%).
- Of those who had heard of the Irish Medical Council (n=136), between 45% and 58% were aware of the Irish Medical Council's four main functions - fitness to practise (58%), ethical guidance (54%), registration (52%) and education (45%). Forty-two per cent were unaware of any of its functions.

3.4.5 Preferences for differing models of medical regulation

Key Finding Six: The majority of respondents (87%) supported professionally led regulation (45%) or regulation with equal numbers of doctors and non-medical members (42%).

Respondents were presented with information about the Irish Medical Council (see below) and were asked to indicate the type of regulation of the medical profession they would prefer (Table 6).

The Irish Medical Council and Self-regulation

The main role of the Medical Council is to protect the public in their dealings with doctors.
The Medical Council:

- sets standards in education and training for doctors
- publishes a register of doctors
- publishes a guide to ethical and professional conduct and
- investigates alleged breeches to this ethical guide.

The Medical Council is established in law and is a self-regulatory body. Self-regulation is where professionals are seen to be in the best position to set and monitor standards. The Council has 25 members, at least four are non-medical. There are a number of alternatives to this model of self-regulation.

Table 6: Public preferences for different types of medical regulation

Types of regulation:	Overall (n=248)		Had heard of Irish Medical Council (n=136)		Had not heard of Irish Medical Council (n=112)	
	N	%	N	%	N	%
1. Self-regulation (as it is now)	13	5	9	7	4	3
2. Self-regulation but with more members of the public on the committee	99	40	52	38	47	42
3. State regulation with equal numbers of doctors and members of the public appointed by government	104	42	59	43	45	40
4. State regulation with members of the public and few or no medical representatives	23	9	12	9	11	10
5. Other (independent of State and medical profession)	9	4	4	3	5	5

- Of 248 respondents, 45% (n=112) supported *self-regulation* or *professionally led regulation* (i.e. regulation by a majority of medical doctors). This comprised 5% (n=13) favouring self-regulation as it is now and 40% (n=99) favouring self-regulation but with more members of the public on the committee.
- Forty-two per cent (n=104) supported *state regulation with equal numbers of doctors and members of the public* appointed by government.
- Therefore, the majority (82%) favoured a system of more public involvement than at present but in conjunction with medical professionals and in approximately equal numbers. Few (n=32; 13%) favoured a system with little or no medical involvement (9%) or a system independent of the State and medical profession (4%).

3.4.6 Events influencing views of the Irish Medical Council

Key Finding Seven: Less than a third of those who had heard of the Irish Medical Council indicated that specific events or experiences influenced their views of the Irish Medical Council over the past ten years.

- Of those who had heard of the Irish Medical Council (n=136), 31% (n=42) indicated that specific events or experiences influenced their views of the Irish Medical Council over the past ten years. These included the Dr. Neary case[2] and general standards in healthcare. Of the 42 respondents, two thirds said these events decreased their confidence in the Irish Medical Council.
- The survey time-frame included the date of the release of the Report of the Lourdes Hospital Inquiry[2]. Of the 68 respondents who remained to be interviewed when the report was released, 72% (n=49) had heard of the report. Of these, 20% (n=10) indicated it had influenced their views of the Irish Medical Council. Seven respondents indicated that the details of the inquiry decreased their confidence in the Irish Medical Council; one reported that it increased their confidence and two reported it had no impact in this regard.

Footnote[2]: *The Report of the Lourdes Hospital Inquiry – An Inquiry into peripartum hysterectomy at Our Lady of Lourdes Hospital in Drogheda* by Judge Maureen Harding Clarke (2006), found that the obstetrician Dr. Neary conducted excessive numbers of caesarean hysterectomies over an extended career..

3.5 Discussion

High level of satisfaction with medical doctors

The study showed that the majority of respondents (84%) were satisfied with the care they received from doctors over the past five years. Those who ever had *a reason* to be dissatisfied with a doctor accounted for 25% (n=63) of respondents.

Dissatisfaction with non-clinical based competencies

Content analysis of reasons for dissatisfaction with doctors identified a list of non-clinical competencies expected among doctors. Examples included that doctors should aspire to (1) spend sufficient time with patients and be available to them when needed, (2) provide patients with value for money and charge fair and appropriate fees, (3) show empathy in caring for patients and (4) actively listen to patients. These issues need to be addressed in medical schools and in further education to promote best practice.

Need to regulate the cost of healthcare

Content analysis also suggested that the cost of health care should be regulated. Many were dissatisfied with the high cost of attending a GP or hospital consultant and felt that they received poor value for money, e.g. little time spent with patient, referral rather than treatment or no diagnosis achieved. This finding is concerning, particularly since a recent cross border survey of the effects of consultation charge on patient access to GPs, found that almost one in five patients (18.9%) in the Republic of Ireland who had a medical problem in the previous year had not consulted their doctor because of cost, compared to just 1.8% of patients in Northern Ireland (Thompson and O'Reilly, 2006).

Responsibility of the healthcare system

The non-clinical competencies expected of doctors highlight their inter-dependence with the health care system, on how it is structured and the resources funding it. In some instances, the public saw doctors as responsible for what were in part failures of the healthcare system. For example, under-investment in medical education has contributed to the shortage of medical personnel and/or excess demand on existing doctors' time.

Need for communication with the public about complaints procedures

A small number of respondents (n=10; 16%) complained following an unsatisfactory experience. A high proportion of respondents (81%, 63%) said they would complain if they did experience dissatisfaction. The finding that common reasons not to complain included not knowing how to complain or to whom to complain, or that complaining was not worthwhile, suggests a need to inform the public about the existence of complaints processes and of their purpose in the healthcare setting. For example, only 55% of respondents had heard of the Irish Medical Council. In addition, while approximately two thirds believed that hospital management, health boards/HSE and the Irish Medical Council deal with complaints, fewer respondents felt this was definitely the case.

Need for a standardised inter-agency approach for dealing with complaints

The findings also suggested the lack of a standardised approach to dealing with complaints. Respondents complained or would have complained to a range of persons/organisations (for example, doctors themselves, health boards/HSE, Irish Medical Council and local politicians). This suggests that there is an absence of a hierarchy of organisations dealing with complaints or of organisations dealing with specific types of complaints. Organisations dealing with complaints need to co-ordinate with one another in pursuit of commonly identified goals.

Need to consider the views of public stakeholders in deciding the numbers of medical and non-medical members of the Irish Medical Council

A new Medical Practitioners Act is expected by the end of 2006. It is important to consider the finding that 87% favoured some form of professional regulation, either professionally-led regulation (45%) or regulation with equal numbers of medical and lay members (42%). Few (n=32; 13%) favoured abolishing a significant role for doctors or the State in regulating medical practice. This is the first evidence available from the general public on this issue. Their aspiration for more balanced representation of medical and public expertise in medical regulation should be seriously considered by those determining the parameters of medical regulation in the new Act.

3.6 Conclusion

In conclusion, this survey has collected valuable data on public satisfaction with doctors, on their willingness to complain and on their perceptions of the complaints system. It is hoped the findings will be of assistance to policy makers in devising an effective complaints system.

4 Explanation of Irish Medical Council Complaints Procedure

All complaints are examined under the charge of professional misconduct, defined by the Medical Practitioners Act 1978.

Definition of professional misconduct

(a) Conduct which doctors of experience, competence and good repute consider disgraceful or dishonourable; and/or

(b) Conduct connected with his or her profession in which the doctor concerned has seriously fallen short by omission or commission of the standards of conduct expected among doctors.

The Fitness to Practise (FTP) Committee, which is comprised of Council members, examines complaints on the grounds of (a) alleged professional misconduct or (b) fitness to engage in the practice of medicine by reason of physical or mental disability. If the FTP Committee decides a complaint reveals *prima facie evidence of professional misconduct* (evidence of professional misconduct at first sight or before closer reasoning), the complaint proceeds to a sworn legal inquiry. These complaints are then examined by an Inquiry Committee and the Council. The procedure has six steps:

Step One: The complainant writes a letter of complaint to the Irish Medical Council. The Irish Medical Council sends the letter of complaint to the doctor and his/her observations and comments are requested.

Step Two: The doctor makes a written response to the complaint. The Irish Medical Council sends the response to the complainant and he/she may reply if they wish to do so. If so, the response is forwarded to the doctor for information purposes.

Step Three: All correspondence and documents concerning the complaint are put before the Fitness to Practise Committee to decide whether or not the complaint is serious enough to be heard before an inquiry.
[In most cases, no inquiry is held. Standardised letters informing complainants and doctors of this decision marks the end of this procedure. If an inquiry is held, the complaint proceeds to the next steps].

Step Four: An Inquiry Committee holds a *Fitness to Practise Inquiry* similar to a court or sworn tribunal and the complainant is treated as a witness during the proceedings. The Committee examines all the evidence and considers whether it amounts to professional misconduct or if the doctor is unfit to practise medicine. The Committee produces a report concerning its findings and the report is considered by the Council at a separate subsequent meeting.

Step Five: A Council Hearing takes place. The Council uses the Inquiry Committee report to decide on the action to be taken against the doctor.

Step Six: The doctor is entitled to appeal the Council's decision to the High Court. If no appeal is made the Council is obliged to apply to the High Court to confirm the decision to apply sanctions.

5 Perspectives of Complainants to the Irish Medical Council

5.1 Background

As part of a larger quality improvement programme, the Irish Medical Council commissioned this survey to find out the views of persons who complained to them about medical doctors. The overall aims of the survey were to:

- Identify the motivations for complaining to the Irish Medical Council
- Profile the outcomes wanted from making a complaint
- Evaluate the effectiveness of the Irish Medical Council complaints procedure from the perspectives of complainants
- Profile the effects of making a complaint on individual complainants
- Identify complainants' views of the Irish Medical Council as a regulatory body
- Identify complainants' views of how to improve the complaints procedure.

5.2 Method

The questionnaire was developed based on an international literature review and consultation with Irish Medical Council personnel. A total of 147 complainants were invited to participate in the survey. Those invited were divided into two groups, based on how the Irish Medical Council had treated their complaints (Table 7).

Group 1 [Non Prima Facie (NPF) Cases]: These were persons whose complaints were treated as *non prima facie cases*, i.e. the Irish Medical Council dealt with these complaints by examining written correspondence between the complainant and the doctor (and any other appropriate documentation) and deciding that a sworn legal inquiry was not necessary. The complainants identified (n=183) were those who made complaints over a one year period between September 2004 and August 2005. Exclusion criteria were complaints that were ongoing (n=43) and resolved complaints made by solicitors on behalf of others i.e. complainants who were not directly in contact with the Irish Medical Council (n=11). Of the population identified, 70% (n=129) were invited to participate. They included members of the public (90%), health professionals (8%) and employers (2%).

Group 2 [Prima Facie Cases (PF) Cases]: These were persons whose complaints were treated as *prima facie cases*, i.e. the Irish Medical Council dealt with these complaints through a sworn legal inquiry similar to a court or tribunal. The complainants identified (n=53) were those who made complaints over a three year period between September 2002 and August 2005. The same exclusion criteria as above were applied. In addition, a small number of cases (n=11) which were reported anonymously or which were deemed too sensitive to include were excluded from the sampling frame. Many cases in this group were still in progress (n=26). Thus 34% (n=18) of the population identified were invited to participate. They included members of the public (72%), health professionals (17%) and employers (11%).

Ethical considerations regarding confidentiality of complainants were built into the study design. In order to protect the identity of those to be contacted, Irish Medical Council personnel identified the sample and exclusions as pre-specified and issued the invitation to participate in the research with an accompanying letter of information from the researchers.

The questionnaire was administered, ideally using telephone but also postal methods because the phone numbers of all complainants were not available.

Table 7: Description of the sampling frame of complainants

	NPF Cases (Sept 2004-Aug 2005)		PF Cases (Sept 2002-Aug 2005)	
	Sample Frame	Sample selected	Sample Frame	Sample selected
	N	N	N	N
Total Cases:	183	129	54	18
Type of complainant:				
Public	150	116	20	13
Health professional	17	10	11	3
Employer	3	3	5	2
Irish Medical Council	1	0	16	0
Other	12	0	2	0
Type of complaint:				
Treatment	57	40	11	5
Professional standards	44	29	23	5
Failure to communicate/rudeness	34	32	0	0
Failure to supply medical records	12	4	1	1
Alcohol/drug abuse/ irresponsible prescribing	10	7	10	4
Failure to attend	6	5	4	3
Advertising	3	1	1	0
Responsibility to colleagues	2	2	0	0
Certification	1	0	0	0
Convictions	0	0	1	0
Physical/mental disability	0	0	3	1
Other complaints	14	9	0	0

5.3 Profile of Participants

- **Response rate:** A 54% response rate was achieved with 74 of 138 persons contacted completing questionnaires (41 telephone and 33 postal). There was a 55% response rate among NPF cases (67 of 122 responded) and a 44% response rate among PF cases (7 of 16 responded). These response rates provide useful insights on previously unresearched groups.
- Complainants (86%) were mostly patients themselves (n=45) or relatives/friends of patients (n=19). Seven per cent were health professionals, 4% were employers and 3% were other types of complainants.
- **Profile of NPF Cases (n=67):** 46% were men, 61% were married and 61% were aged 45 years and over. Approximately half lived in urban areas, a third lived in rural areas and 16% lived in towns. There was a high level of education among respondents. Thirty per cent were educated to Leaving Cert and 58% to Post Leaving Cert/ Third Level standards. Most (60%) were in employment.
- **Profile of PF Cases (n=7):** Four were men and five were aged 45 years and over. They lived in urban (n=2), town (n=2) and rural areas (n=3).

5.4 Results

Seven key findings were identified. Findings that relate to NPF or PF cases in particular are indicated.

5.4.1 Motivation to complain

Key Finding One: Respondents complained about a combination of factors related to treatment, behaviour and communication. While complaints varied in seriousness and complexity, poor communication was a common issue across the majority of complaints.

- **NPF Cases (n=67):** Respondents complained because of a combination of factors (Table 8). Poor communication was predominant among these factors. Seventy-two per cent complained because of communication issues; 58% because of unprofessional behaviour; 42% because of clinical care issues and 39% because of "other issues", e.g. inappropriate prescribing, advertising, slanderous comments, loss of medical records and mistreatment and diagnosis of patients in psychiatric care.

Table 8: Complainant descriptions of the reasons for the complaint

Category of Complaint	NPF Cases (n=67)		PF Cases (n=7)	
	N	%	N	%
1) Clinical care				
Failure to diagnose or incorrect diagnosis	23	34	0	0
Incompetent treatment of a medical condition	24	36	2	29
Inappropriate treatment causing an adverse outcome	24	36	2	29
Total respondents	**28**	**42**	**2**	**29**
2) Poor or inadequate communication				
Rudeness	40	60	3	43
Failure to fully inform of the details of a condition	20	30	2	29
Failure to fully inform of the side effects of taking a particular course of medicinal drugs	12	18	0	0
Failure to fully inform of the risks of undergoing a particular medical procedure	8	12	1	14
Total respondents	**48**	**72**	**4**	**57**
3) Unprofessional behaviour				
Abusive behaviour	18	27	4	57
Refusal to treat	14	21	3	43
Failure to refer to the appropriate specialist	9	13	1	14
Breach of confidentiality of doctor-patient relationship	13	19	2	29
Inappropriate delay in the treatment required	15	22	4	57
Overcharging	4	6	2	29
Total respondents	**39**	**58**	**6**	**86**
4) Other issues	**26**	**39**	**6**	**86**

- In terms of the four categories of complaint displayed in Table 8, 34% complained for reasons relating to one category only and the remainder complained for reasons relating to two (31%), three (22%) or all four (12%) categories.
- Respondents reported that the most important reason that caused them to complain were clinical care issues (27%), unprofessional behaviour (26%), communication issues (21%) and the "other issues" (26%) previously described.
- **PF Cases (n=7):** The most important reason for these complaints were unprofessional behaviour (n=4) and other issues (n=3).
- Overall, respondents complained about GPs (55%), hospital consultants (38%), non- consultant hospital doctors (4%) and other types of doctor (3%).

5.4.2 Stress involved in complaining

Key Finding Two: Over three quarters found the decision to make the complaint to the Irish Medical Council stressful.

- Seventy-nine per cent found the experience of making a complaint stressful to varying degrees, with 42% finding it "stressful" to "very stressful". Many reported that they did not want to make a complaint but that events compelled them to do so. Others felt stress in recounting the events or incident that caused the dissatisfaction in the first place. Still others were stressed by an unsatisfactory outcome to the complaint.

5.4.3 Awareness of agencies responsible for complaints

Key Finding Three: Most complainants (82%) had a low level of awareness of the different routes available to members of the public to make complaints about doctors.

- At the time of making the complaint, the vast majority (82%) were unaware of other channels (besides the Irish Medical Council) for members of the public to make complaints about doctors. This was despite the fact that two thirds (n=44) had complained to other persons or bodies before complaining to the Irish Medical Council. These mainly complained to the doctor concerned (48%), other health professionals (18%) or health boards (16%). Of those who complained directly to the doctor concerned (n=24), 79% indicated that the attitude of the doctor in response to their concerns had a major effect on their decision to take the complaint to the Irish Medical Council.
- Respondents (47%) were most likely to have become aware of the Irish Medical Council through a range of information networks such as relatives or friends, Citizen's Advice, the telephone directory and local GPs. Others became aware of them through the media (26%) and other types of health professionals (18%).

5.4.4 Outcomes wanted and achieved by complaining

Key Finding Four: Respondents listed a range of outcomes they wanted to achieve by complaining. Approximately two thirds felt they achieved none of these.

(A) Outcomes Wanted:

- **NPF Cases:** Most wanted to prevent the unsatisfactory practise from being continued or repeated (91%), or to receive an explanation (72%) or an apology (63%) or to have disciplinary action, such as a warning (66%), taken against the doctor (Table 9).

Table 9: Complainant indications of the outcomes wanted from making the complaint

Outcomes wanted:	NPF Cases (n=67)		PF Cases (n=7)	
	N	%	N	%
1. ..to prevent an unsatisfactory practice being continued or repeated	61	91	5	71
2. ..the doctor to learn from his/her mistake	57	85	4	57
3. ..my grievance acknowledged by the doctor	55	82	5	71
4. ..an explanation from the doctor	48	72	3	43
5. ..the doctor to receive a warning	44	66	4	57
6. ..my difficulty with the doctor sorted out	44	66	2	29
7. ..an apology from the doctor	42	63	2	29
8. ..conditions attached to the doctor's employment	19	28	1	14
9. ..the doctor to have to work under supervision	18	27	3	43
10. ..alternative medical care to be arranged on my (patients) behalf	15	22	1	14
11. ..the doctor to be identified publicly as incompetent	14	21	1	14
12. ..the doctor suspended from his/her job	8	12	1	14
13. ..the doctor's licence to practise medicine revoked	8	12	1	14
14. ..financial compensation	7	10	1	14
15. ..other outcomes	28	42	1	14

- A smaller group wanted the doctor to have to work under supervision (27%), to have conditions attached to his/her employment (28%) and to be publicly identified as incompetent (21%). Others wanted alternative medical care to be arranged on their behalf (22%) or financial compensation (10%). Forty-two per cent (n=28) described "other outcomes" they wanted to accomplish, for example ascertaining the truth, justice or understanding or for the doctor to be informally disciplined.
- PF Cases: Notably, the findings regarding PF cases were similar to the NPF cases. Thus, in what were clearly determined by the Irish Medical Council to be more serious cases to answer by the doctors involved, complainants were no more likely to want outcomes different to those who reported cases deemed to be less serious. It is noteworthy that the Irish Medical Council does not have to power to formally warn a doctor (through censure, admonishment or advice), to attach conditions to a doctor's employment, to suspend a doctor from his/her employment or to revoke a doctor's licence to practise medicine unless the complaint is treated as a *prima facie* case.

(B) Outcomes achieved:

- Of the 74 respondents, approximately two thirds (n=50) felt they achieved none of the purposes for which they complained.
- NPF Cases: Table 10 lists complainants' awareness of the outcomes they achieved. Approximately three quarters (72%) of these respondents felt they achieved "none of the purposes" for which they complained, 19% felt they achieved "some but not all of the purposes", 7% felt they achieved "all purposes" and 2% did not know.

Table 10: Complainant indications of the outcomes achieved by complaining to Irish Medical Council

Outcomes achieved:	NPF Cases (n=67)					
	Yes		No		I don't know	
	N	%	N	%	N	%
1. My complaint was acknowledged	61	91	6	9	0	0
2. My complaint was investigated	41	61	13	19	13	19
3. The doctor gave me an explanation	19	28	48	72	0	0
4. The doctor apologised to me	13	19	53	79	1	2
5. My difficulty with the doctor was sorted out	6	9	59	89	1	2
6. The doctor learned from his/her mistake and the unsatisfactory practice did not reoccur	1	2	32	48	34	51
7. The doctor received a warning	1	2	43	64	23	34
8. The doctor had to work under supervision	0	0	57	85	10	15
9. Conditions were attached to the doctors employment	0	0	56	84	11	16
10. The doctor was suspended from his job	0	0	61	91	6	9
11. The doctor was publicly identified as incompetent	0	0	60	90	7	10
12. The doctor's licence to practise medicine was revoked	0	0	61	91	6	9
13. I received financial compensation	0	0	67	100	0	0
14. Alternative medical care was arranged on my behalf (on behalf of the patient concerned).	0	0	67	100	0	0
15. Nothing happened as a result of making my complaint	36	54	25	37	6	9

- Most indicated their complaint was acknowledged (91%) and 61% felt their complaint had been investigated. However, relatively few reported that the doctor gave them an explanation (28%) and apologised (19%). Only 9% reported that their difficulty with the doctor was sorted. The majority were either unsure (51%) or felt the doctor had not learned from the mistake (48%). Ninety-eight per cent were either unsure (34%) or felt the doctor did not receive a warning (64%). A worrying half (54%) felt that *nothing* happened as a result of their complaint.
- PF Cases: Two respondents felt they achieved "all purposes" for which they complained, three felt they achieved "some but not all purposes" and two felt they achieved "none of the purposes".

5.4.5 Evaluation of the complaints procedure

Key Finding Five: Respondents were asked a series of questions to evaluate each step of the complaints procedure (see explanation of procedure in Section 4). In general they rated the information received as adequate and the procedure itself as useful. Dissatisfactory issues rated to the transparency of decision-making and the outcomes of complaints (Table 11).

(A) Adequacy of information

- **In general, respondents were satisfied with how they were treated by Irish Medical Council staff and with the information they received about the complaints procedure.**
- When respondents contacted the Irish Medical Council in relation to the complaint, 74% were satisfied with the behaviour of staff towards them. Those who were dissatisfied (14%) felt that communication was limited to mainly written correspondence.
- Most respondents reported they received information about how the complaints procedure works (92%), about their role and involvement in the complaints procedure (81%) and about the possible outcomes of the complaint (80%). Approximately two thirds rated the information as "adequate" to "very adequate". Those who were dissatisfied (18%-24%) felt the information was too generic and that it did not explain legal terms sufficiently. For example, they felt it did not clearly specify what constitutes a "*prima facie case*". They felt that clearer information is necessary to allow people to know what outcomes to expect from using the Irish Medical Council complaints procedure.

(B) Impact of the letter writing procedure

- **Respondents rated the letter writing procedure as useful, but felt it was not effective in resolving the issues of the complaint or in improving the quality of medical services.**
- Respondents (72%) found the letter writing procedure between the doctor and the complainant useful to varying degrees, with 47% finding it "useful" to "very useful". However, in most cases, the procedure did not resolve the issues of the complaint. Of those who received a reply from the doctor (90%), only 6% were satisfied with the response received. Those who were dissatisfied felt doctors' replies were untruthful or did not specifically address the complaint made. Their dissatisfaction was exacerbated by views that the Irish Medical Council did not question the doctor's response or address any differences between the letters.
- Sixty-three per cent disagreed with the statement that *the Medical Council provides an opportunity for reconciliation and closure between the doctor and the complainant.* At the end of the complaints process, 93% did not feel reconciled with the doctor and 78% did not achieve a sense of closure on the issue.
- Only 14% perceived that their complaint had the effect of improving the quality of services provided by the medical profession.

(C) Transparency of explanations regarding decisions made

- **Over half of respondents felt that the procedure for informing them that their complaints did not necessitate an inquiry, lacked transparency and adequate explanation. Two thirds were dissatisfied with the decision (NPF cases).**
- When the Fitness to Practise Committee considers that a complaint does not call into question a doctors fitness to practise medicine, complainants are informed by standard letter of the decision not to hold an inquiry (and thereby of the end to the complaints process). Many felt this procedure lacked transparency; 56% indicated that the reasons for the decision were not explained to them. Of these, 94% would have liked to have known the reasons.
- Sixty-five per cent were dissatisfied with the decision not to hold an inquiry. Those satisfied (19%) felt that their complaint did not warrant an inquiry, whereas those who were dissatisfied felt that they were not believed, that the truth was not established and that no action was taken as a result of the complaint. Some also felt angry because they did not know how the complaint was investigated and what information was examined.
- Overall, 63% disagreed with the statement that *the Medical Council is a transparent organisation, the process of regulation is clear and explanations are given for decisions made.*

(D) Satisfaction with outcome of complaint

- **Most complainants (81%) were dissatisfied with the outcome of the complaint. This was closely related to the design of the complaints procedure (NPF cases).**
- **NPF Cases:** Seventy-two per cent felt the complaints procedure was inappropriately designed to meet their objectives. Content analysis showed that they believed the procedure (1) was biased towards doctors, (2) did not investigate, adjudicate and take appropriate action following complaints and (3) used inappropriate criteria and mechanisms for dealing with low level complaints. This dissatisfaction was reflected in recommendations to allow verbal communication between parties and to grade responses to complaints. Hence 81% were dissatisfied with the outcome of the complaint and only 5% felt the doctor was disciplined.
- **NPF + PF Cases:** Furthermore, 44% said that the outcome of the complaint impacted negatively on their ability to trust doctors in general, 40% said it had no impact and 16% said it impacted positively.

(E) Views of the complaints procedure in terms of principles of best practice

- **Respondents rated the complaints procedure highly in terms of accessibility, simplicity, speed and confidentiality. Areas identified for improvement included impartiality, accountability and responsiveness.**
- The complaints procedure was evaluated in terms of principles of best practice. Seventy-seven per cent reported that they did not feel intimidated by the Irish Medical Council complaints procedure itself; 69% felt the complaints procedure was simple and straight-forward; 63% were satisfied with the length of time from complaint to outcome, and 55% perceived that their complaint was treated confidentially by Irish Medical Council staff and 31% did not know.

Table 11: Summary of Complainant perspectives of the Irish Medical Council's complaints process

Findings regarding NPF cases only:	N	%
1. How satisfied were you with the outcome of the complaint?		
Satisfied	9	14
Neither satisfied/dissatisfied	3	5
Dissatisfied	52	81
2. How satisfied were you with the decision not to hold an inquiry?		
Satisfied	12	19
Neither satisfied/dissatisfied	10	16
Dissatisfied	40	65
3. Were the reasons for the decision not to hold an inquiry explained to you?		
Yes	26	42
No	35	56
I don't know	1	2
4. Do you feel the doctor was disciplined in any way?		
Yes	3	5
No	40	63
I don't know	20	32
5. Do you feel the complaints procedure was appropriately designed to meet your objectives?		
Yes	18	27
No	48	72
I don't know	1	1
Findings regarding both NPF and PF cases:		
1. Was the Irish Medical Council biased in how they handled the complaint?		
No, they gave equal support to the doctor and myself	27	38
Yes, they gave more support to the doctor	36	50
No, they gave more support to myself	1	1
I don't know	8	11
2. At the end of the complaints process did you feel reconciled with the doctor?		
Yes	5	7
No	67	93
3. Did you achieve a sense of closure on the issue?		
Yes	16	22
No	56	78
4. How did the outcome of making a complaint impact upon your ability to trust doctors in general?		
It impacted positively	12	16
It had no impact	29	40
It impacted negatively	32	44
5. Do you think the complaint you made had the effect of improving the quality of the services provided by the medical profession?		
Yes	10	14
No	46	62
Unsure	18	24

Footnote: *NPF Cases* - the Irish Medical Council dealt with these complaints by examining written correspondence between the complainant and the doctor (and any other appropriate documentation) and deciding that a sworn legal inquiry was not necessary; *PF Cases* – the Irish Medical Council dealt with these complaints by holding a sworn legal inquiry.

Some issues were identified as challenging:

- *Impartiality*: Only 18% agreed the Irish Medical Council is sufficiently independent from the medical profession to make fair decisions about complaints while 38% agreed that the Irish Medical Council gave equal support to the doctor and themselves as complainants.
- *Accountability*: Over two thirds (68%) agreed that the medical profession are too powerful for an average person to win against them in any forum and 45% did not know if the Irish Medical Council takes responsibility at the most senior levels for the operation of its complaints procedure.
- *Responsiveness*: Two thirds (66%) agreed that the Irish Medical Council did not acknowledge the human and stressful nature of the experience for them. One in five (20%) agreed that the medical care they receive would be compromised as a result of the complaint made.

5.4.6 Views regarding Fitness to Practise Inquiries

Key Finding Six: **Few respondents had experience of fitness to practise (FTP) inquiries. However, approximately two thirds viewed the suggestion to hold FTP inquiries in public as problematic.**

- Of the 74 respondents, a minority (31%) agreed that fitness to practise inquiries should be held in public. The remainder (69%) either agreed to some extent (38%) or disagreed (31%). Those who agreed felt that public inquiries would address the need for transparency in the complaints process, for doctors to be held publicly accountable and for appropriate communication between all parties. Those who agreed to some extent felt that decisions to hold inquiries in public should be dependent on the wishes of the complainant and on the sensitivity and type of complaint. Those who disagreed felt that public inquiries would deter people with complaints from coming forward, that trial by public media is inappropriate, that the public lack knowledge to judge medical inquiries and that there are alternative and more appropriate ways of ensuring transparency in the complaints process.
- PF Cases: Findings challenged the appropriateness of having the same members of the FTP Committee who uphold complaints, on the Inquiry Panel and on the Sanction Board. This should be reviewed. Furthermore, protocols are needed to ensure witnesses are treated with appropriate sensitivity during the inquiry process, e.g. during cross examination.

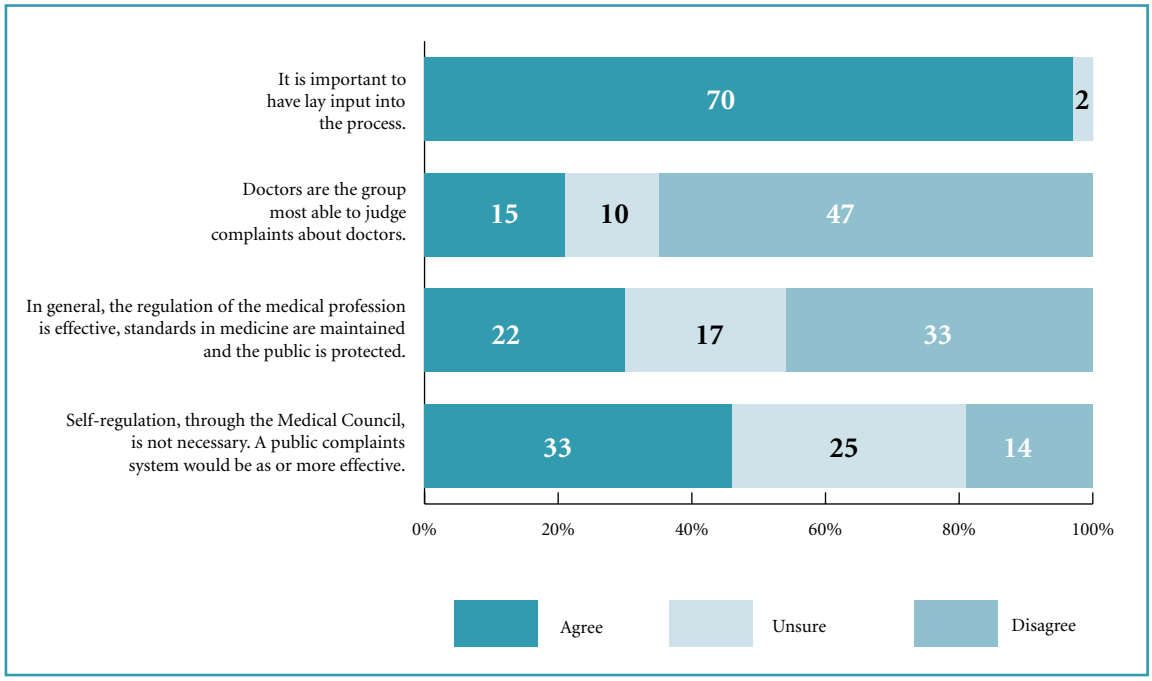
5.4.7 Views of and how to improve medical regulation

Key Finding Seven: **Respondents felt the regulatory process needs to be improved and modernised. They questioned the necessity of self-regulation through the Irish Medical Council, but were uncertain of the effectiveness of alternatives.**

Figure 5 shows complainant views of the medical regulatory process.

- Respondents strongly supported lay involvement in medical regulation (97%) and questioned the primacy of doctors in the complaints process – 65% disagreed that *doctors are the group most able to judge complaints about doctors.*
- While 30% agreed with the statement that *the regulation of the medical profession is effective, standards in medicine are maintained and the public is protected*, 46% disagreed and 24% were unsure. These mixed views show that there was limited support for the continuance of the current system of self-regulation. However, some respondents were unsure of the effectiveness of the alternatives – 46% agreed that *self-regulation through the Irish Medical Council is not necessary, a public complaints system would be as or more effective*, 19% disagreed and 35% were unsure.

Figure 5: Complainant views on medical regulation (n=72)



- Respondents (n=69; 93%) provided a list of 147 recommendations for improving the Irish Medical Council complaints procedure. The six core recommendations were to:

  (a) Review and revise the complaints procedure to ensure it provides for (a) transparent investigations (n=12) (b) graded responses to complaints (n=9) (c) informal resolution (n=8) (d) tangible outcomes (n=14) and (e) explanations for decisions not to proceed to fitness to practise inquiries (n=14).

  (b) Thoroughly investigate complaints by improving strategies for communicating with complainants. For example, provide opportunities for verbal communication or interview of complainants (n=23).

  (c) Facilitate transparency by improved information provision (n=19). For example, provide information on (a) what constitutes a prima facie case, (b) how investigations are carried out, (c) the instruction or sanction made to the doctor, irrespective of whether an inquiry is held, (d) the number of complaints upheld per annum and on (e) the people who are on the Fitness to Practise Committee.

  (d) Develop initiatives to ensure and demonstrate that regulation is independent of the medical profession. For example, involve doctors from different jurisdictions in the Medical Council and declare conflicts of interest (n=12).

  (e) Review procedures for holding fitness to practise inquiries (n=11).

  (f) Ensure there is sufficient public representation on the Irish Medical Council (n=6).

5.5 Discussion

This research has, for the first time in Ireland, examined the medical regulatory system from the point of view of persons who have made formal complaints. The key findings have implications for the mode of regulation that will be developed under the new Medical Practitioners Act and for the broader statutory complaints system.

Complaints – a reflection of the need for a comprehensive system of competence assurance for doctors

Respondents complained about a combination of issues including treatment, behaviour and communication. The complaints made varied in seriousness and complexity. Factors that support the Irish Medical Council's plans for a comprehensive system of competence assurance include the increased numbers of complaints presenting to them over past ten years and the recent well publicised failures of members of the medical profession to implement systems of audit (Report of the Lourdes Hospital Inquiry, 2006). The finding that communication issues were common across all complaints suggests that interventions are required to identify and combat barriers to good communication practices.

The complaints procedure – at odds with complainant expectations and some regulatory principles of best practice

Most respondents (NPF cases) were dissatisfied with the outcome of the complaint (81%) and felt they achieved none of the purposes for which they complained (68%). This finding was directly related to the Irish Medical Council's inability to meet complainants' expectations. A factor often cited as limiting the Irish Medical Council is the fact that it is a statutory body, governed by a Medical Practitioners Act established almost thirty years ago (1978). By law, its focus in dealing with complaints is deciding whether or not the doctor is fit to practise medicine. Therefore, complaints which are judged not to call into question a doctor's fitness to practise medicine inevitably result in a statement that there is no prima facie case for the holding of a sworn legal inquiry. There is no adjudication or comment on the complaint and no explanation of why a sworn legal inquiry is not necessary. This organisational response was hugely unsatisfactory to complainants – both to those who felt their complaints were of sufficient gravity to necessitate a fitness to practise inquiry and those who had low level complaints and did not expect an inquiry to be held but did expect some lesser form of investigation and/or sanction. While doctors are obliged by law to make a written response to the complaints, in general complainants found their responses unsatisfactory and would have liked the Irish Medical Council to mediate the issue.

The Irish Medical Council method for dealing with complaints is based on a strict legal model and thus is out of line with some important regulatory principles of best practice. For many, complaining proved to be a negative experience and resulted in negative perceptions of Irish Medical Council, as an organisation. The lack of explanation to accompany statements that a complaint did not show prima facie evidence of professional misconduct led to anger and frustration. Some felt that their complaints were dismissed or that they were not believed. This in turn led to the perception that the Irish Medical Council protects doctors and takes a doctor's word over those of members of the public. Some perceived that legal terminology was being used to mask an absence of impartiality, transparency and accountability. Some did not believe the problem was confined to outdated legislation.

The need for review of the purpose of the complaints procedure and appropriate investigations

The findings suggest the need for a review of the purpose of the Irish Medical Council complaints procedure. As stated, its system is designed to deal with complaints that call into question a doctor's fitness to practise medicine, yet it processes low level complaints, for example about rudeness and poor inter-personal skills. The question emerging is whether the Irish Medical Council is the appropriate place for such complaints? Perhaps an inter-agency approach for dealing with complaints is required. This could be made possible through the development of protocols of the types of complaints applicable to each agency and through increased liaison between the appropriate agencies. Communicating the various avenues available to the public to make complaints about doctors is of utmost importance if we are to claim to have a national complaints system. For instance, 82% of complainants to the Irish Medical Council were unaware of other avenues to make complaints about doctors.

The need for improved communication with complainants

The need for appropriate communication with complainants was a major finding of this study. Complainants indicated they wanted appropriate information at the beginning of the complaints process. In particular they wanted a better understanding of what constitutes a "*prima facie case*" so they would not feel like they wasted their time complaining. They felt that the Irish Medical Council could be clearer at the beginning about how it deals with complaints and about what outcomes it can achieve for complainants.

Often complainants felt that their complaints were not properly investigated. This was directly related to the fact that all communication with the Irish Medical Council was done through written correspondence. Correspondence from the Irish Medical Council was confined to standardised legally-formulated letters. Furthermore, many alluded to the difficulty of writing the complexities of a complaint in a letter. They felt that verbal communication (e.g. interview of the complainant) should have been an integral part of the investigation process. Many were open to resolving complaints informally through a meeting with the Irish Medical Council and the doctor concerned. The lack of verbal communication is likely to have contributed to perceptions among some complainants that doctors were unaccountable and that the Irish Medical Council "swept complaints under the carpet".

Where to from here?

In summary, the findings of this survey show the need for improvements in the operation of the complaints procedure. While recent media debate has focused on the numbers of public and medical persons that should make up the Irish Medical Council under the new Act, the subject of adequate public representation was only raised in 4% of complainant recommendations. In drafting the new Act, attention should be paid to the key findings of the study, in particular to resolving issues actually found to be unsatisfactory.

5.6 Conclusion

In conclusion, it is hoped that this research will help policy makers manage complainant expectations and respond more adequately to complaints. Policy makers should ensure that the larger complaints system is integrated and that the purpose of the Irish Medical Council complaints procedure is clear and communicated to all stakeholders. The complaints procedure must be made effective and updated in line with regulatory principles of best practice.

Perceptions of the Irish Medical Council reported from this survey have been based entirely on their fitness to practise work. This is only one aspect of its overall role. Fitness to practise is a function that is not possible without the participation of members of the public. It is crucial that the public perceive the Irish Medical Council as impartial and participate in the process. The new Act provides a unique opportunity for the Irish Medical Council to improve its complaints process and thus the overall standard, including accountability of the medical profession.

5.7 Recommendations

The recommendations of this particular stakeholder group were highlighted in the key findings. These recommendations, together with the recommendations arising from the other surveys, were used to produce the list of conclusions in Section 1.4.

6 Perspectives of Doctors about whom the Irish Medical Council received Complaints

6.1 Background

As part of a larger quality improvement programme, the Irish Medical Council commissioned this survey to find out the views of doctors who were complained to the Irish Medical Council. This group was identified as important stakeholders because they would have first hand knowledge and experience of the Irish Medical Council complaints procedures.

The overall aims of the survey were to:

- Identify doctors' views of the reasons for the complaints
- Evaluate the effectiveness of the Irish Medical Council complaints procedure from the perspectives of doctors complained of in this system
- Profile the effects of receiving a complaint on individual doctors
- Identify doctors' views of the Irish Medical Council as a regulatory body
- Identify doctors' views of how to improve the complaints procedure.

6.2 Method

A postal questionnaire was developed based on an international literature review and consultation with Irish Medical Council personnel. A total of 195 doctors were invited to participate in the survey. Those invited were divided into two groups, based on how the Irish Medical Council treated the complaints made against them (Table 12).

Group 1 [Non Prima Facie (NPF) Cases]: the complaints made about doctors in this group were treated as *non prima facie cases*, i.e. the Irish Medical Council facilitated and examined written correspondence between the doctor and the complainant (and any other appropriate documentation) and decided that a sworn legal inquiry was not necessary. The doctors targeted (n=240) were those complained over a one year period, between September 2004 and August 2005. Only those whose complaints were resolved (n=164; 68%) were invited to participate. The sample contacted included hospital consultants (32%), non-consultant hospital doctors (2%) and GPs (66%). The majority (70%) of complaints concerned treatment (33%), professional standards (19%) and communication issues (18%).

Group 2 [Prima Facie (PF) Cases]: the complaints made about doctors in this group were treated as *prima facie cases*, i.e. the Irish Medical Council dealt with the complaints by holding a sworn legal inquiry similar to a court or tribunal. The doctors targeted (n=57) were complained of over a three year period, between September 2002 and August 2005. Only those whose complaints were resolved (n=31; 54%) were invited to participate. The sample included hospital consultants (16%), NCHDs (19%) and GPs (65%). The complaints mainly concerned alcohol/drug abuse/irresponsible prescribing (n=7), treatment (n=8) and professional standards (n=8).

Ethical considerations were built into the study design to ensure a sensitive approach towards those surveyed. Irish Medical Council staff compiled an anonymous listing of the doctors complained of by gender, age group, nationality (EU or non EU), type of doctor (GP or hospital consultant) and type of complainant for the purposes of research team analysis and anonymity outside the Irish Medical Council was maintained. Following appropriate exclusions, Irish Medical Council personnel invited the doctors to participate via an information pack containing the postal questionnaire, a letter of invitation and further information from the research team. Responses were forwarded to researchers from those who chose to participate.

Table 12: Description of sampling frame of doctors about whom the Irish Medical Council received complaints

	NPF Cases (Sept 2004-Aug 2005)		PF Cases (Sept 2002-Aug 2005)	
	Sample Frame	Sample selected	Sample Frame	Sample selected
	N	N	N	N
Total Cases:	240	164	57	31
Type of doctor:				
Hospital Consultant	71	52	16	5
NCHD	13	4	10	6
GP	156	108	31	20
Gender:				
Male	184	123	48	26
Female	56	41	9	5
Age group:				
50 years and over	113	84	39	14
Under 50 years	127	80	18	17
Nationality:				
EU	201	148	36	17
Non-EU	39	16	21	14
Type of complaint:				
Treatment	96	55	14	8
Professional standards	46	31	23	8
Failure to communicate/rudeness	31	29	0	0
Alcohol/drug abuse/ irresponsible prescribing	14	9	10	7
Advertising	13	7	1	0
Failure to supply medical records	12	11	1	1
Failure to attend	6	5	4	4
Responsibility to colleagues	3	3	0	0
Certification	1	0	0	0
Convictions	1	0	1	1
Physical/mental disability	0	0	3	2
Other complaints	17	14	0	0
Type of complainant:				
Public	187	128	23	16
Health professional	19	11	11	3
Employer	3	3	5	3
Irish Medical Council	9	4	16	8
Other	22	18	2	1

6.3 Profile of Participants

- **Response rate:** A 60% response rate was achieved (117 of 195 questionnaires were returned). This response rate, on such a sensitive topic, means that the findings can be taken as broadly representative of the population targeted. There was a 64% response rate among NPF cases (105 of 164 responded) and a 39% response rate among PF cases (12 of 31 responded) in particular. Considering the particular sensitivity and seriousness of the subject matter in PF cases, a 39% response rate can provide useful insights on a previously unresearched group.
- **Profile of NPF Cases (n=105):** 71% were men; half were aged 50 years and over; the majority were EU citizens (91%); 58% were GPs, 33% were hospital consultants, 7% were NCHDs and 2% were other types of doctors. Most were complained about by members of the public (80%).
- **Profile of PF Cases (n=12):** Ten were men; half were aged 50 years and over; eight were EU citizens; four were hospital consultants, four were NCHDs, two were GPs and two were unspecified. Seven were complained about by a member of the public, two by a health professional, two by employers and one by another source.
- Comparison of NPF and PF cases highlight some interesting issues. The ratio of male to female doctors is approximately 3 to 1 in NPF cases but 5 to 1 in PF cases. This shows a higher proportion of male doctors having more serious (PF) cases made against them. Professional standards and substance abuse/ inappropriate prescribing complaints were evident in a higher proportion of the PF cases. None of the more serious (PF) cases related to communication failures.

6.4 Results

Seven key findings were identified. Those that relate to NPF or PF cases in particular are identified.

6.4.1 Doctors' categorisation of the type of complaint made

Key Finding One: Doctors reported that they were complained of for a combination of reasons relating to treatment, behaviour and communication.

- Doctors indicated the complaints made against them. These were not necessarily their personal views of these events.
- **NPF Cases:** Doctors reported that the complaints related to clinical care (29%), communication (29%), unprofessional behaviour (28%) and other issues (39%). The "other issues" included advertising (n=7); medical certificates/report disputes (n=5); irresponsible prescribing/misuse of drugs (n=3); discrimination (n=3); management issues (n=2); the fact that the doctor's name was one among many mentioned in a letter of complaint (n=2); conflicts of interest (n=4), hygiene (n=1) and other miscellaneous issues (n=13) (Table 13).
- Over three quarters (78%) reported they received complaints relating to one category only - clinical care (19%), communication (17%), unprofessional behaviour (13%) and the other issues described above (29%).
- **PF Cases:** Complaints that lead to an inquiry included unprofessional behaviour and clinical care issues.

6.4.2 Doctors' views of the reason for the complaint

Key Finding Two: Unrealistic expectations of patients and patient anger towards doctors were viewed as paramount in the reasons for complaints.

- **NPF Cases:** Doctors most often cited unrealistic expectations (25%) and patient anger towards them (26%) as reasons for the complaints. This was followed by patient perceptions of inappropriate behaviour (20%), medical error (19%), patient instability (19%) and poor communication (17%). Thirty-eight per cent also cited "other issues" such as professional rivalry, grief reactions and conflicts of interest.

Table 13: Doctors' categorisations of complaints made against them

Category of Complaint	NPF Cases (n=103)		PF Cases (n=12)	
	N	%	N	%
1) Clinical care				
Failure to diagnose or incorrect diagnosis	13	13	4	33
Incompetent treatment of a medical condition	15	15	2	17
Inappropriate treatment causing adverse outcomes	12	12	1	8
Total respondents	**30**	**29**	**5**	**42**
2) Poor or inadequate communication				
Rudeness	17	17	1	8
Failure to communicate	17	17	0	0
Total respondents	**30**	**29**	**1**	**8**
3) Unprofessional behaviour				
Abusive behaviour	6	6	0	0
Refusal to treat	12	12	1	8
Failure to refer	6	6	0	0
Breach of confidence	2	2	0	0
Unacceptable delay in treatment	5	5	0	0
Overcharging	3	3	0	0
Total respondents	**29**	**28**	**1**	**8**
4) Other issues	**40**	**39**	**7**	**58**

6.4.3 Evaluation of the complaints procedure

Key Finding Three: Doctors were asked a series of questions to evaluate each step of the complaints procedure (see explanation of procedure in Section 4). In general they rated the information they received as adequate and the procedure itself as useful. Most were satisfied with the outcome of the complaint. Dissatisfactory issues related to the transparency of decision-making and the punishing aspects of participating in the process (Table 14).

(A) Adequacy of information

- **In general, doctors were satisfied with how they were treated by Irish Medical Council staff and with the information they received about the complaints procedure.**
- When respondents contacted the Irish Medical Council staff in relation to the complaint, 56% were satisfied with the behaviour of staff towards them and 31% were neither satisfied nor dissatisfied.
- Most respondents reported they received information about how the complaints procedure works (79%), about their role and involvement in the complaints procedure (81%) and about the possible outcomes of having a complaint made against them (65%). Approximately two thirds (61% to 69%) rated the information as "adequate" to "very adequate".

(B) Impact of the letter writing procedure

- **Doctors rated the letter writing procedure as useful. However, it was not viewed as effective in resolving the issues of the complaint.**
- Doctors (79%) found the letter writing procedure between the complainant and themselves useful to varying degrees, with 59% finding it "useful" to "very useful". Approximately two-thirds indicated that the complainant replied to their response to the complaint, however, only 12% were satisfied with the response they received. The main reasons for the low levels of satisfaction were respondents' views that complainant replies were emotive, factually incorrect or did not address their response, serving to reinforce the initial complaint.
- Furthermore, 44% disagreed with the statement that *the Medical Council provides an opportunity for reconciliation and closure between the doctor and the complainant.* At the end of the complaints process, 91% did not feel reconciled with the complainant and 32% did not achieve a sense of closure on the issue.

(C) Transparency of explanations regarding decisions made

- **Almost half felt that the procedure for informing doctors that the complaint did not warrant an inquiry lacked transparency (NPF cases).**
- All doctors are informed by standard letter of a decision not to hold an inquiry. However, this procedure was not viewed as transparent by all; 46% felt the reasons for the decision were not explained to them. They viewed the standard response of "no prima-facie case" as insufficient. Of these, 70% would have liked to have known the reasons.
- However, 91% were satisfied with the decision not to hold an inquiry and the same proportion believed the decision upheld the Irish Medical Council role to protect the public.
- Overall, 27% disagreed with the statement that *the Medical Council is a transparent organisation, the process of regulation is clear and explanations are given for decisions made.* A further 31% neither agreed nor disagreed or did not know.

(D) Satisfaction with outcome of complaint

- **Most were satisfied with the outcome of the complaint. Dissatisfactory issues related to the lack of a graded response to complaints and to the punishing aspects of participating in the process (NPF cases).**
- Doctors were satisfied with the outcome of the complaint (83%) and with the support they received from their medical defence bodies (84%) and legal teams (79%). However, only 54% were satisfied with how the Irish Medical Council handled the complaint. This lower level of satisfaction arose mainly from respondents' disappointment that the Irish Medical Council processed "trivial", "unjustified", "trifling" or "malicious" complaints. These respondents were dissatisfied because the same procedure was seen to apply to all complaints irrespective of their seriousness.
- Although an inquiry was not held in these cases, one in three (38%) felt disciplined by (1) the legal obligation to respond to the complaint, (2) by the levels of stress and anxiety created, (3) by feeling punished by participating in the process and (4) by having no method of redress against false allegations.

Table 14: Summary of Doctors' perspectives of the Irish Medical Council's complaints process

Findings regarding NPF cases only:	N	%
1. How satisfied were you with the outcome of the complaint?		
Satisfied	84	83
Neither satisfied/dissatisfied	11	11
Dissatisfied	6	6
2. How satisfied were you with how the Irish Medical Council handled the complaint?		
Satisfied	54	54
Neither satisfied/dissatisfied	26	26
Dissatisfied	20	20
2. How satisfied were you with the decision not to hold an inquiry?		
Satisfied	90	91
Neither satisfied/dissatisfied	5	5
Dissatisfied	4	4
3. Were the reasons for the decision not to hold an inquiry explained to you?		
Yes	55	54
No	47	46
4. Do you think the decision not to hold an inquiry upheld the Irish Medical Council role to protect the public?		
Yes	86	91
No	9	9
5. Although an inquiry was not held, do you feel you were disciplined in any way?		
Yes	39	38
No	63	62
Findings regarding both NPF and PF cases:		
1. Was the Irish Medical Council biased in how they handled the complaint?		
No, they gave equal support to the complainant and myself	74	68
Yes, they gave more support to the complainant	31	29
No, they gave more support to myself	0	0
I don't know	3	2
2. At the end of the complaints process did you feel reconciled with the complainant?		
Yes	9	9
No	95	91
3. Did you achieve a sense of closure on the issue?		
Yes	35	32
No	75	68
4. Did receiving a complaint benefit you in anyway?		
Yes	35	30
No	80	70
5. Do you think the complainant benefited from making the complaint?		
Yes	56	49
No	43	37
Unsure	16	14

Footnote: *NPF Cases* – the Irish Medical Council dealt with these complaints by examining written correspondence between the complainant and the doctor (and any other appropriate documentation) and deciding that a sworn legal inquiry was not necessary; *PF Cases* – the Irish Medical Council dealt with these complaints by holding a sworn legal inquiry.

(E) Views of the complaints procedure in terms of principles of best practice

- **Doctors felt complaints were treated confidentially and impartiality. However, they felt that the management of the complaint did not acknowledge the human and stressful nature of the experience for them**.
- The complaints procedure was evaluated in terms of principles of best practice. Doctors felt it best exemplified the principles of confidentiality and impartiality; 71% agreed that the complaint was treated confidentially, 68% agreed that the Irish Medical Council gave equal support to the complainant and themselves and 63% felt the Irish Medical Council was sufficiently independent from the medical profession to make fair decisions about complaints. Some issues were identified as challenging:
- *Responsiveness:* Many (69%) agreed that the Irish Medical Council did not acknowledge the human and stressful nature of the experience for them. One in two felt intimidated by the complaints procedure. Nine per cent believed their status as medical practitioners would be compromised as a result of the complaint.
- *Speed:* One in three was dissatisfied with the length of time from complaint to outcome.
- *Simplicity:* One in four felt the procedure was complex.

6.4.4 Effects of complaints on doctors

Key Finding Four: **Complaints exerted an emotional pressure on doctors. They were viewed as promoting defensive medicine rather than improving the quality of patient care.**

- Over all cases, 72% found receiving the complaint either "stressful" or "very stressful". A similar proportion (70%) felt that receiving the complaint did not benefit them in any way.
- NPF Cases: On receipt of the complaint, doctors reported feeling shock (81%) and anger towards the complainant (85%) and the Irish Medical Council (33%). Over the course of dealing with the complaint, they reported feeling angry (75%) and depressed (39%), had doubts about their clinical competence (20%) and had difficulties interacting with patients (20%), family and friends (20%). As a result of the complaint, about two thirds (64%) said they were now more likely to practise medicine defensively. Other effects were reduced fulfilment in the practise of medicine (39%), loss of trust in patients (28%) and a reduced ability to work confidently and decisively (18%).

6.4.5 Perceptions of the Irish Medical Council as a regulatory body

Key Finding Five: **Respondents rated the Irish Medical Council as an effective regulator of the medical profession. Areas identified for improvement were the transparency of its decision making and organisational protocols for judging complaints.**

- Respondents (n=115) rated the Irish Medical Council as performing well in its ability to uphold professional accountability (85%), to act as a deterrent against malpractice and corruption in the profession (81%) and to regulate the medical profession effectively, ensuring standards in medicine and the protection of the public (77%). Sixty-two per cent agreed that the Irish Medical Council judges doctors by appropriate standards.
- Two aspects of the Irish Medical Council's role – its ability to discriminate between failings attributable to healthcare systems, error in the practise of medicine and wrong-doing (49%) and to the need to have members appropriately trained and properly experienced with fair and appropriate judgement (56%) – were not rated as highly as others. Many were unaware of how the Irish Medical Council met these requirements in particular.

6.4.6 Views regarding Fitness to Practise Inquiries

Key Finding Six: **Those who experienced a fitness to practise inquiry had mixed views about them. Overall, the vast majority (82%) viewed the suggestion to hold fitness to practise inquiries in public as problematic.**

- Only a small number of doctors experienced fitness to practise inquiries (n=12). All but one were satisfied with the information they received and believed the inquiry was conducted impartiality (n=11). Eight of twelve respondents were satisfied with the findings of the Inquiry Committee and seven of ten were satisfied with the sanction recommended. The sanctions imposed included no sanction (n=6), censure,

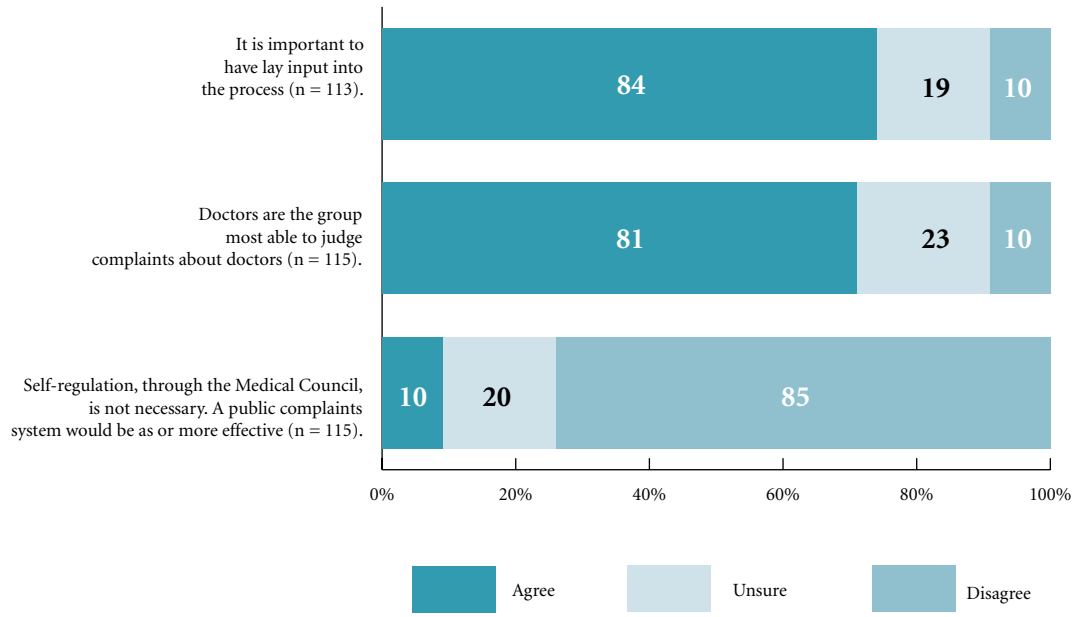
admonishment or advice (n=2), conditions imposed on practising (n=2), suspension (n=2) and erasure from the Register (n=1). Those who rated the appropriateness of the sanctions described them as very appropriate (n=3), inappropriate (n=1) and very inappropriate (n=3). Conditions imposed were described as punitive and distressing.

- Most respondents (n=94; 82%) disagreed with the proposal to hold fitness to practise inquiries in public. Reasons included that public inquiries would (1) damage a doctor's reputation – whether found innocent or guilty, (2) lead to sensationalist and inaccurate media reporting, (3) increase the stress for both parties, (4) breach the confidentiality of the doctor-patient relationship, (5) prevent court cases from being heard and (6) deter those interested in a career in medicine.

6.4.7 Views of and how to improve medical regulation

Key Finding Seven: Doctors generally supported self-regulation with public involvement and felt that doctors were the group most able to judge complaints about doctors (Figure 6). However, they raised concerns that the current mode of self-regulation needs to be modernised and updated.

Figure 6: Doctors views on how the medical profession should be regulated



- Respondents supported having public involvement in the process (74%), but also agreed that doctors were the group most able to judge complaints about doctors (71%) and that self-regulation through the Medical Council was a necessity (74%).
- Respondents felt the current mode of self-regulation needs to be updated. They (n=96; 82%) provided an extensive list of 172 overlapping recommendations for improving the Irish Medical Council complaints procedure. The five core recommendations were to:

  (a) Review and revise the complaint procedure to incorporate: (a) screening (n=20), (b) grading responses to complaints (n=14), (c) informal resolution (n=10) and (d) providing reasons for decisions not to proceed to fitness to practise inquiries (n=6).

  (b) Improve strategies for communicating with doctors by: (a) improving provision of information on the complaints procedure and actual complaint made (n=15), (b) updating doctors regarding the progress of complaints (n=6) and (c) personalising correspondence to doctors at notification of and closure to the complaint (n=14).

  (c) Make the complaints procedure as speedy and efficient as possible (n=20).

  (d) Set up a mechanism to ensure redress for doctors who have false complaints made against them (n=14).

  (e) Provide support services to doctors to address any emotional trauma as a result of the complaint (n=10).

6.5 Discussion

This survey has for the first time examined the medical regulatory system in Ireland from the point of view of doctors who received complaints. The findings have significance for the new mode of regulation that will be developed under the new Medical Practitioners Act as outlined next:

The need for a broader responsibility for maintaining standards

The finding that the public comprised the majority of complainants raises questions about responsibility for reporting doctors seen to be practising below appropriate standards. It is possible that many of the instances complained about were observed by other professionals in the healthcare setting. For the purposes of learning and maintaining standards, there may be a need to identify and counter barriers preventing health professionals from raising concerns of serious nature in greater numbers.

The importance of managing doctor-patient interaction

Views of the reasons for complaints suggested that unrealistic expectations and patient anger are paramount in the genesis of complaints. This finding reflects the mismatch between the ideal delivery of healthcare and the reality experienced by doctors and patients. There are implications therefore for how doctors interact with patients, manage patients' expectations and minimise patient dissatisfaction.

The need to minimise the negative impacts of complaints on how medicine is practised

Rather than improving the quality of patient care, doctors stated that complaints promoted defensive medicine. This finding suggests that complaints have the potential to negatively effect doctors' perceptions of their own competence and the quality of the broader doctor patient relationship in the long-term. For example, this research found that as a result of the complaint, 39% experienced less fulfilment in the practice of medicine, 28% lost trust in patients generally and 18% were less able to practise medicine confidently and decisively. Similar findings were found in a study by Cunningham (2004) of the immediate and long-term impact on New Zealand doctors who received patient complaints. In that study, doctors experienced reduced ability to tolerate uncertainty in their practice of medicine (42%), reduced confidence in their clinical judgement (30%) and were less able to consult well (57%) in the immediate 6 week period following the complaint. The study showed that the impact of complaints lessened in the long-term, but some retained reduced trust (32%) and reduced goodwill towards patients (18%). Unfortunately, these findings show that quality enhancement - a fundamental principal that should be contained in complaints procedures (Wilson Report; 1994) is not always achieved through procedures set up to deal with complaints about doctors. They suggest a need for a dialogue on what the purposes of the complaints system should be and on how to minimize the negative impacts of complaints on doctors in their everyday working lives.

The need for emotional supports for doctors

Findings that described the emotional effects of complaints raised concerns not only for patient care but also for doctors themselves. For example, 72% of respondents in our study found receiving the complaint "stressful" to "very stressful" and over the course of dealing with the complaint, 75% (NPF cases) felt angry and 39% felt depressed. As documented above, these emotional effects transferred into difficulties in doctors' working lives. The findings suggest a need to resource supports to help doctors cope with and manage complaints. These resources should be clearly separate from the complaints system to ensure that they do not, and cannot be reasonably seen to, undermine the validity of the complaints process.

The need to incorporate doctors' rights into the complaints process

The evaluation of the Irish Medical Council complaints procedure showed that it was effective at incorporating most principles of best practice, for example those of impartiality and confidentiality. However, there was a sense that doctors' rights should be recognised and incorporated into the procedure. For example, doctors' need for vindication was reflected in calls for explanations for decisions not to proceed to inquiries. Their need to be treated with sensitivity and without stigmatisation was evident in calls for personalised communication rather than standardised legally-formulated letters, at notification of and resolution to the complaint. Their rights to be treated fairly and appropriately were articulated through recommendations to screen and grade responses to complaints and to minimise the punishing aspects of participating in the procedure. While not a prioritised recommendation by those responding, some felt there was a need for informal resolution to facilitate reconciliation between the doctor and the complainant.

Views of the Irish Medical Council as an effective regulator of the medical profession

Respondents rated the Irish Medical Council as an effective regulator of the medical profession, particularly in the areas of upholding professional accountability, in deterring malpractice and in ensuring standards and the protection of the public. These are very progressive findings. They have been identified by the Queenstown Report (2003) as desirable attributes of a complaints system. However, the findings pointed to the difficulties involved in judging the competencies of doctors. Many were unaware of how the Irish Medical Council performed this function and felt it was not carried out in a transparent manner. These findings support the need to demonstrate how decisions are made and to develop strategies to ensure the organisation is viewed as transparent.

The need to modernise the regulatory process

The findings identifying strong support for self-regulation with adequate public involvement and those identifying doctors as the group most able to judge complaints about other doctors should be taken into account in deciding how the Irish Medical Council should be structured under the new Medical Practitioners Act. The overall findings show that improving the regulatory system depends on operationalising principles of better regulation (e.g. transparency, accountability, effectiveness) through the complaints procedure.

6.6 Conclusion

In conclusion, this research study has provided valuable data on doctors' perceptions of the Irish Medical Council and its complaints procedure; albeit from doctors who have had some experience of the complaints system only. Ultimately, the findings described views that self-regulation or professionally led regulation needs to be maintained but that reforms are necessary. They show that the Irish Medical Council is viewed as an effective regulator of the medical profession but that there are key areas requiring improvement. The views of this stakeholder group should be valued and acted upon to ensure the regulatory process is experienced as fair by both doctors and complainants. It is hoped that these findings will be used to inform the system of regulation being developed under the new Medical Practitioners Act.

6.7 Recommendations

The recommendations of this particular stakeholder group were highlighted in the key findings. These recommendations, together with the recommendations arising from the other surveys, were used to produce the list of conclusions in Section 1.4.

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